UMPQUA HEALTH

WELCOME TO UMPQUA HEALTH ALLIANCE

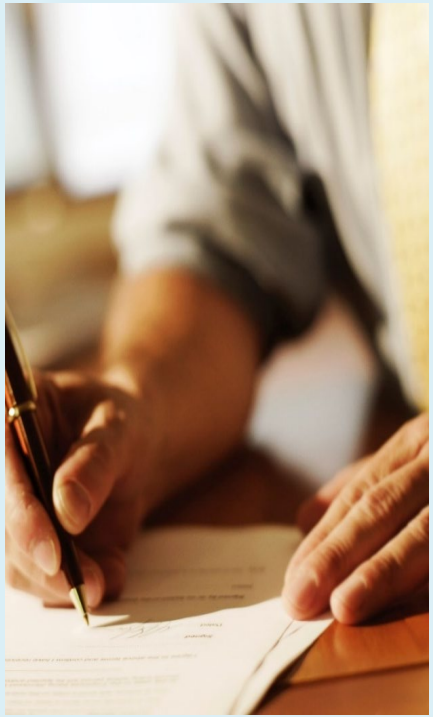
2025 ORIENTATION & TRAINING MANUAL

PROVIDERS AND SUBCONTRACTORS

TRAINING OVERVIEW

This slide deck is designed as a tool to help you understand your responsibilities, as well as UHA's expectations of contracted providers, facilities, and/or subcontractors. It also serves as a guide to help you locate and access information about UHA's processes and policies. Newly employed staff should be provided this training at onboarding.

- Annual training refreshers for current employees should be provided no later than the employment anniversary date.
- Please complete the required attestation after completing the trainings. The attestation lets UHA know that providers and staff understand and agree to comply with all contractual requirements listed in this training.
- We recommend maintaining training records on all providers and practice training activities, which may include certificates, attendance records, or any other relevant documentation that UHA may use to verify mandatory training requirements are satisfied. If these documents are requested, you will receive detailed submission instructions.



UHA's policies and Provider Training resources are available on UHA's website:

PROVIDER & SUBCONTRACTOR TRAININGS

The policy explain the process of the provider and subcontractor training is available at:

POLICY NAME: PN6- PROVIDER OREIENTATION AND TRAINING

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TRAINING OVERVIEW

Accessibility

This information is available in other formats, including extra large font, other languages, and an oral version. To request an alternative format, please contact: uhnproviderservices@umpquahealth.com.

TRAINING OVERVIEW

Introduction to Oregon Health Plan, CCOs

Module 1: CIM Portal

Module 2: Utilization Management

Module 3: Member Engagement

Module 4: Claims

Module 5: Customer Care

Module 6: Provider Data Management

Module 7: Language Access

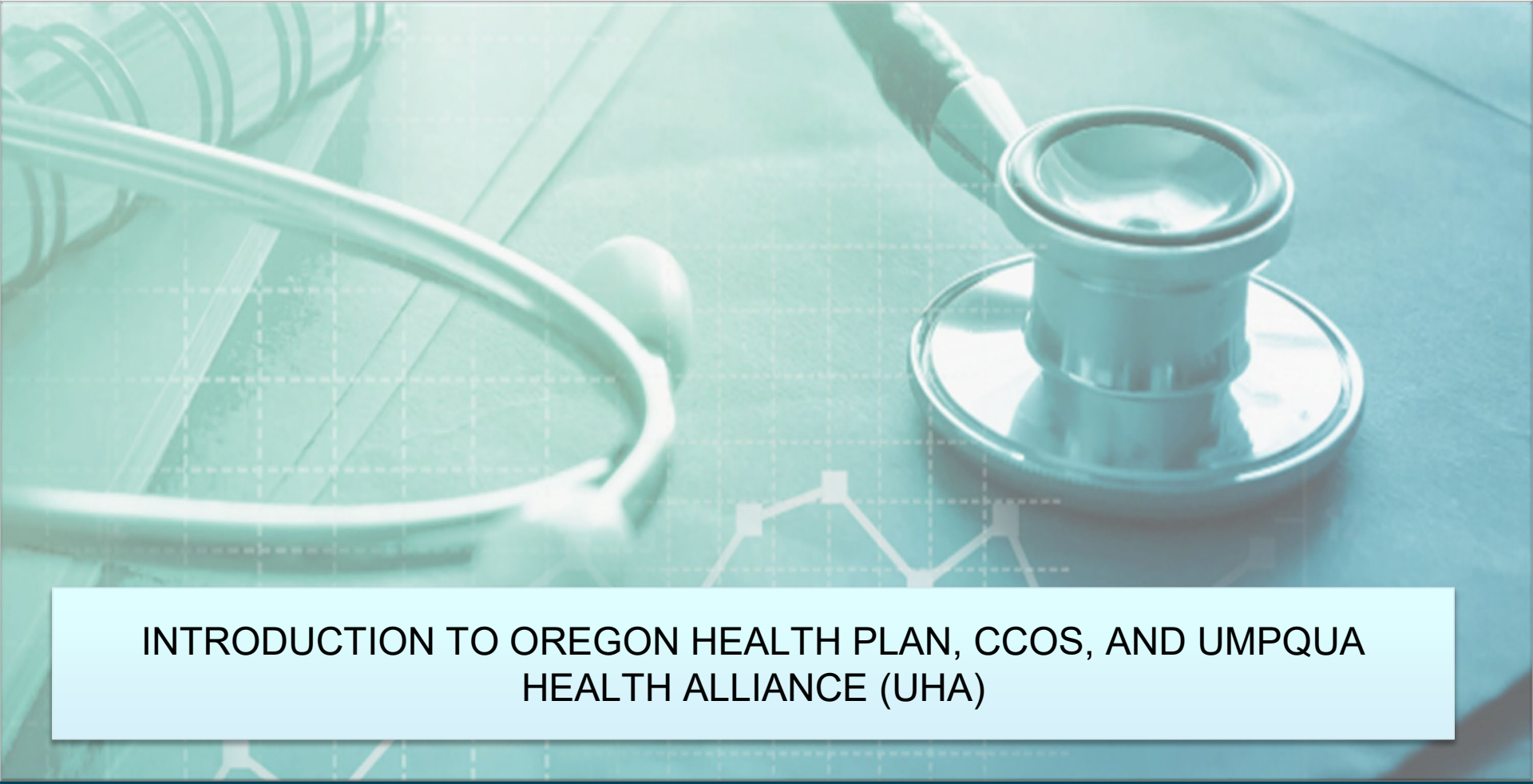
Module 8: Cultural Responsiveness

Module 9: Behavioral Health

Module 10: Compliance & FWA Prevention

Tools and Resources

Contacts



INTRODUCTION TO OREGON HEALTH PLAN, CCOS, AND UMPQUA HEALTH ALLIANCE (UHA)

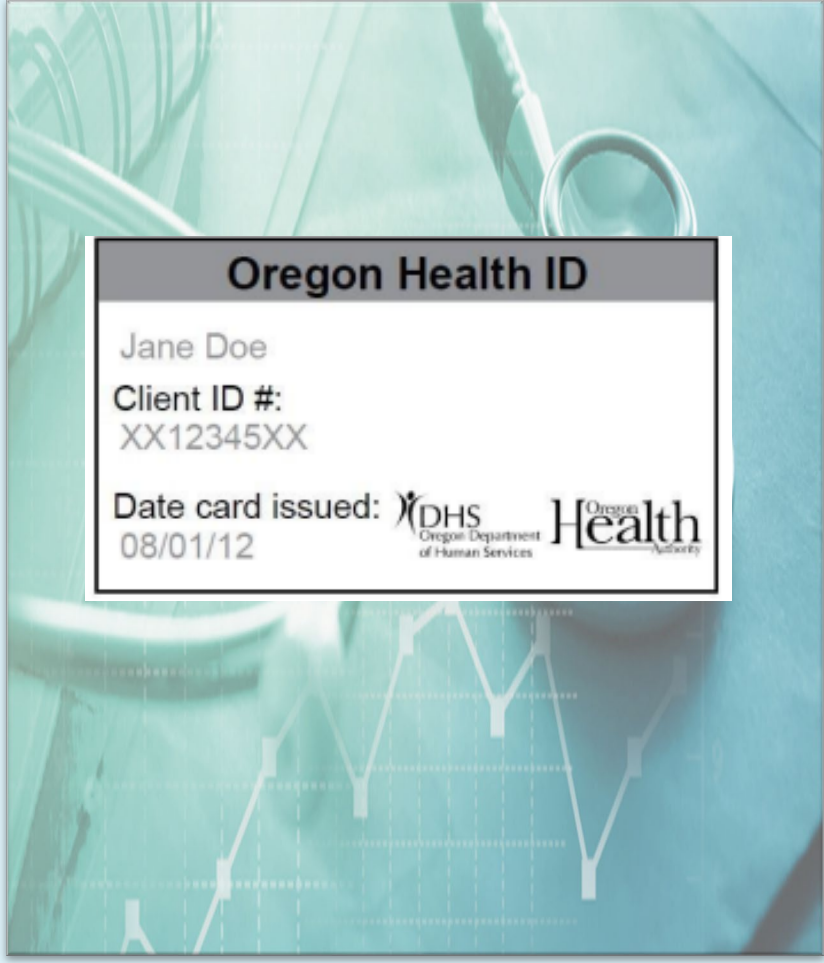
UMPQUA HEALTH

What is a CCO?

- Coordinated Care Organizations (CCOs) provide Medicaid (OHP) health care coverage.
- CCOs were created to make it easier to access the health care services, and providers, that Oregonians need.
- There are 16 CCOs in Oregon, each have different service areas and some of them overlap.
- CCOs are local companies, that are based in the same communities as their members.

What is OHP?

- In Oregon, Medicaid is called Oregon Health Plan (OHP).
- Each state manages Medicaid differently.



Bridge Basic

OHP Bridge is a new health coverage benefit for adults with income just above the traditional OHP Plus limit. Adults with income between 138 and 200 percent of the federal poverty level (FPL) will have access to quality health insurance through OHP Bridge.

OHP Bridge will cover medical, dental and behavioral health care. Members will have access to additional benefits, like transportation to medical appointments and health-related services. However, OHP Bridge will not cover long-term services and supports or climate and housing benefits.

Healthier Oregon

As of July 1, 2023, people of any age or immigration status are eligible for full Oregon Health Plan (OHP) benefits and services for people with disabilities.
The Healthier Oregon program offers free health coverage through the Oregon Health Plan for people who live in Oregon and meet income and other criteria.

Umpqua Health Alliance

Umpqua Health Alliance (UHA) is one of Oregon's 16 coordinated care organizations (CCOs). Umpqua Health Alliance ensures our members have access to the physical, behavioral, oral, and dental care they need at the right time and in the right place.

Emergency In case of a true emergency, call 911 or go to your nearest emergency room **Nurse Advice Line:** 1-888-516-6166 **Dental Emergency:** 1-866-268-9631 **24-hour Mental Health Crisis Line** 1-800-866-9780	**Umpqua Health Alliance - CCOA** **Member Name:** «first_name» «last_name» **Member ID:** «member_number» **Customer Care:** 541-229-4842 **Toll Free:** 1-866-672-1551 **TTY Users:** 541-440-6304 | 711 **Website:** www.UmpquaHealth.com
Primary - Dental - Mental Health «provider_office_name» «provider_ph_hdr» «dental_name» «dental_phone» **You have Mental Health coverage** **Routine Vision coverage for ages 20 and younger.**	**Non-Emergent Medical Transportation:** BCB: 877-324-8109 **Pharmacy Billing** Retail, Specialty & Mail Order Bin: 003585 Retail & Specialty GRP/PCN: 38920 Mail Order GRP/PCN: 116027 **If you need language assistance,** call Linguava at 503-265-8515, 711, or UHA Customer Care at 541-229-4842

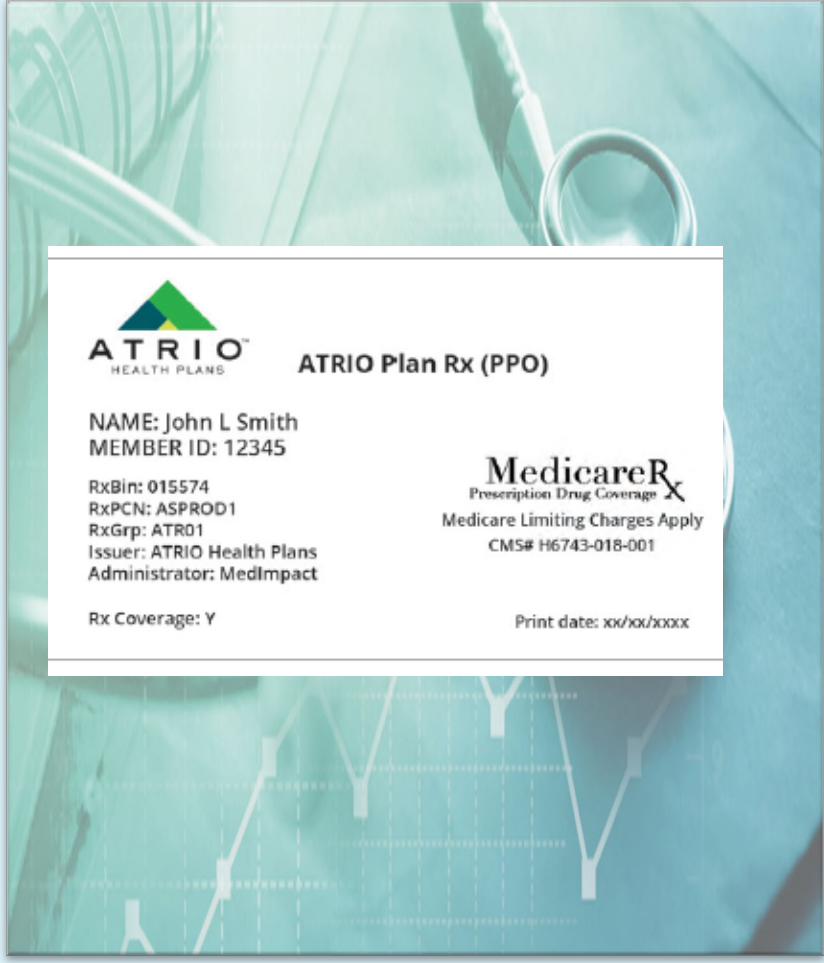
CCO Coverage Models in Oregon

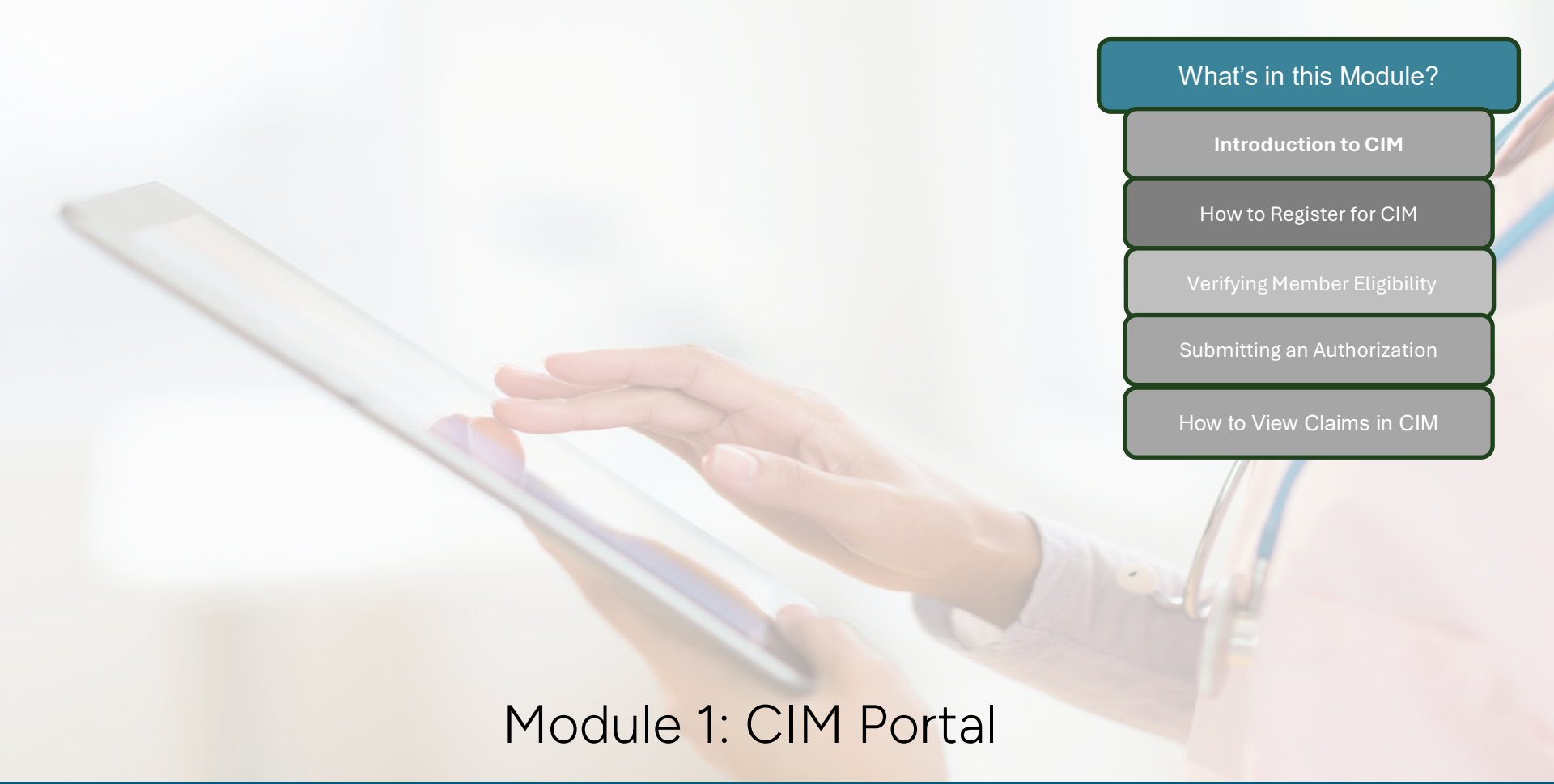
- **CCOA**
  The CCO is responsible for **physical health**, **dental**, and **behavioral health** services.
  → *Full coverage provided by the CCO.*
- **CCOB**
  The CCO provides **physical** and **behavioral health** care.
  Dental care is handled separately by **OHA**.
  → *Split responsibility between CCO and OHA.*
- **CCOG**
  The CCO covers **dental** and **behavioral health** services.
  Physical health care is managed by **OHA**.
  → *CCO excludes physical health coverage.*
- **CCOE**
  Only **behavioral health** is covered by the CCO.
  Physical and **dental** services are managed by **OHA**.
  → *Most limited CCO involvement.*
- ***CCOF***
  The CCO provides **dental care**.
  Physical and behavioral health may be covered by either **OHA** or a CCO, depending on the **OHP Plus member's assignment**.
  → *Coverage varies—check individual member details.*

CCOA	Physical, Behavioral, Oral Health
CCOB	Physical, Behavioral Health
CCOE	Behavioral Health
CCOF	Oral Health
CCOG	Behavioral and Oral Health

Atrio

Atrio Health Plan is a Provider sponsored health plan in Oregon, serving thousands of members in Douglas, Josephine, Jackson, Klamath, Marion and Polk countries. They offer Medicare Advantage coverage to Oregon residents, helping cover the cost of services provided by hospitals, doctors , lab tests and preventive screenings.





Module 1: CIM Portal

What's in this Module?

- **Introduction to CIM**
- How to Register for CIM
- Verifying Member Eligibility
- Submitting an Authorization
- How to View Claims in CIM

Introduction to CIM

What is CIM?

The Community Integration Manager (CIM) is a secure, online portal developed by Ayin Health Solutions to support healthcare providers in managing patient care more efficiently. CIM brings together key tools and information in one easy-to-use platform — giving you quick access to patient eligibility, prior authorizations, and claims data whenever you need it.

Key Features of the CIM Portal

Healthcare providers can use the CIM Portal to efficiently manage a range of administrative tasks — anytime, 24/7. The portal is available around the clock, giving providers the flexibility to access and manage information on their own schedule.

- **Check Patient Eligibility**
  Quickly verify if a patient is eligible for health plan services at any time.
- **Review Claims**
  Track submitted claims and monitor their status or outcomes whenever needed.
- **Submit Prior Authorizations**
  Request approval for services that require health plan authorization — day or night.

How to Register for CIM

Step 1: Complete the Registration Form
Follow the step-by-step instructions provided in [Sign Up for CIM] to complete your registration for the provider portal.

Step 2: Verify Your Email Address
After submitting your registration request:
- Check your email inbox for a verification message.
- **Important:** Also check your **SPAM** or **Junk** folder.
- You **must verify your email** by clicking the link in the email.
- If you do not complete this step, your registration request **will not be received**.

Step 3: Approval Process
Once your email address is verified:
- Your registration request will be reviewed.
- If approved, you will be granted access to the provider portal within **one to seven business days**.

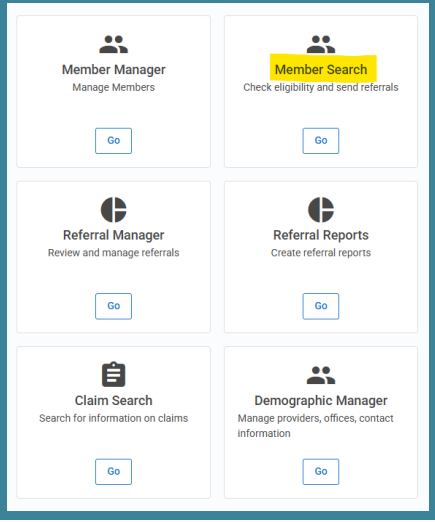
Verifying Member Eligibility in CIM

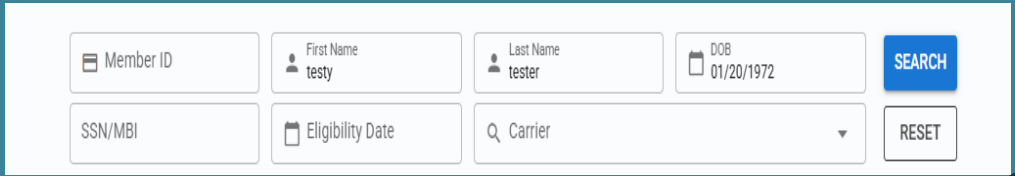
To verify member eligibility:

1. From the **dashboard**, select **Member Search**.
2. In the search fields, enter **one** of the following:
    1. The member's **ID number**,
    2. Or the member's **Name** and **Date of Birth (DOB)**.
3. Click **Search**.

Review the Member Information:

- **Eligibility status** and **plan coverage**
- **Demographic details**, including:
    - Name
    - Date of Birth (DOB)
    - Phone number
- **Patient's care team**, which may include:
    - Primary care provider (PCP)
    - Dentist





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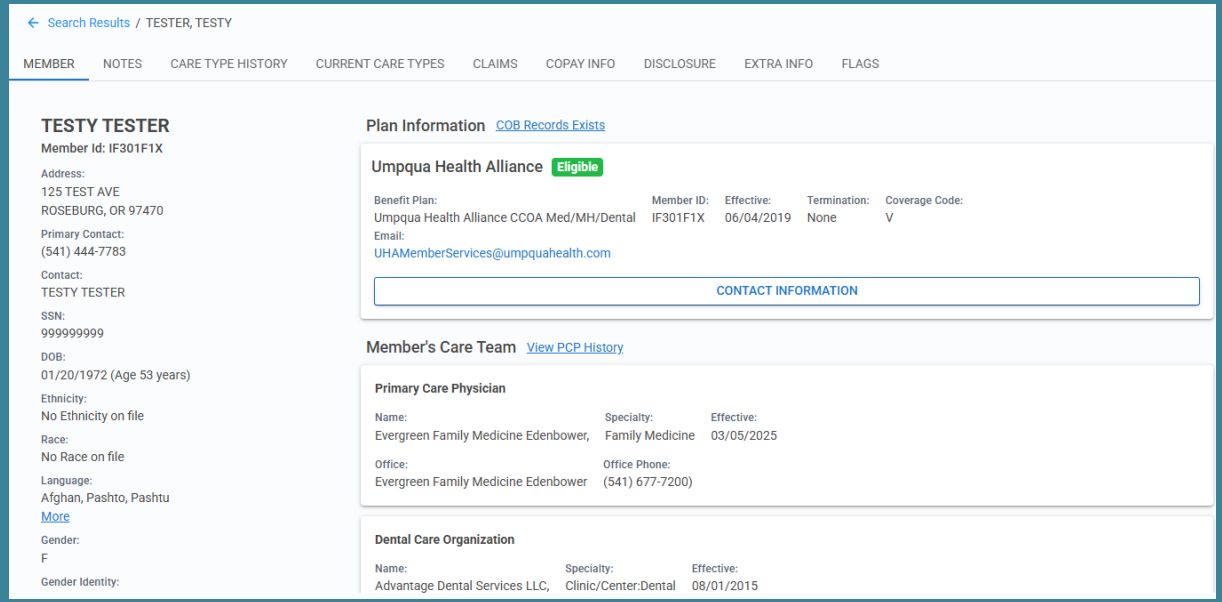
Entering Prior Authorizations in CIM

Verify Member Eligibility
Before submitting a prior authorization request:

- Confirm the member's eligibility for services.
- Review and verify the member's demographic information, including: Name, Date of birth Member , ID Coverage status, and plan details

Submit Pre-Authorization Request
From the main navigation or dashboard, locate and select the "Add New Type of Care" button. In the list of available options, select "Prior Authorization" to begin the request process.



Entering Prior Authorizations in CIM

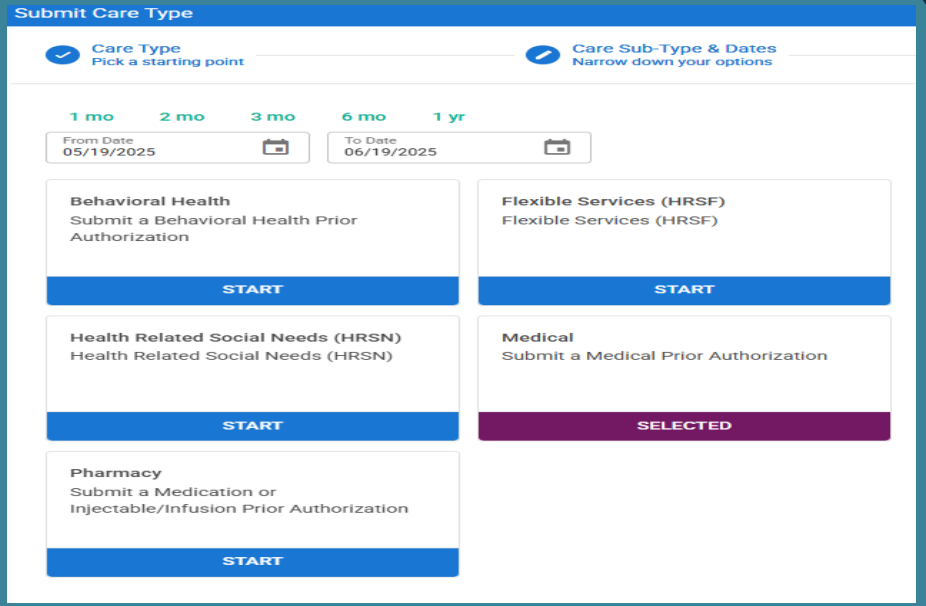
Submit Care Type

1. Select the Date Range
- Choose the **Start Date** and **End Date** for the requested service.
- Ensure the date range accurately reflects the period during which the service will be provided.

2. Choose the Care Type or Service Type
- Under **Care Type** or **Service Type**, select the appropriate category for the service you are requesting prior authorization for.
- Choose the option that best matches the nature of the request.

Available Care Types Include:
- **Behavioral Health**
- **Flexible Services (HRSF)**
- **Health-Related Social Needs (HRSN)**
- **Medical**
- **Pharmacy**

Tip: Selecting the correct care type is critical for timely authorization processing.



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Entering Prior Authorizations in CIM

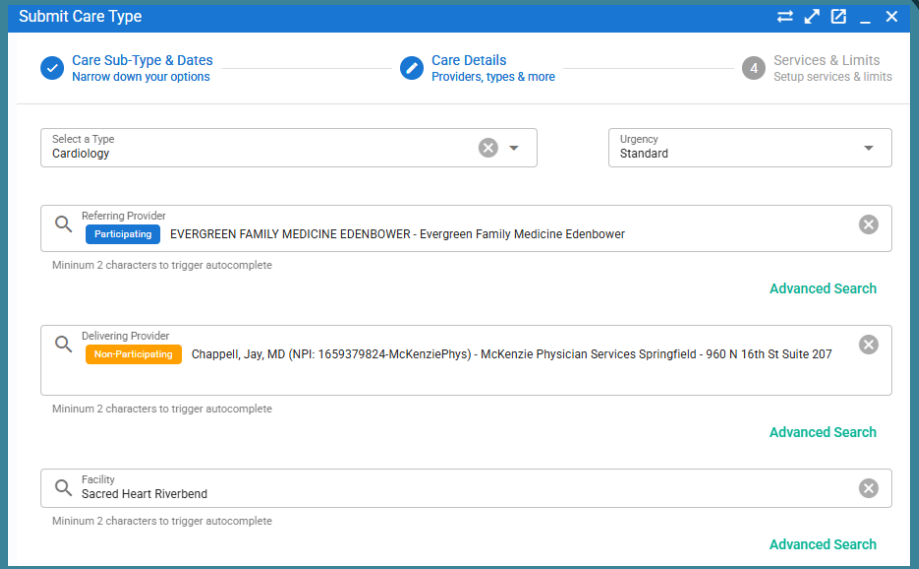
Enter Request Details

After selecting Prior Authorization, complete the required fields to specify the details of the request.

1. Select the Following:

- Type of care Urgency of the request (e.g., Standard, Urgent)
- Referring Provider
- Delivering Provider
- Facility where services will be rendered

Tip: You only need to enter 2 characters in the provider or facility fields to trigger the auto-complete search feature. This will help you quickly find and select the correct provider or location from the directory.



Entering Prior Authorizations in CIM

Enter Clinical Information

1. Enter the Diagnosis Code(s):
- Use ICD-10 codes to identify the member's diagnosis.

2. Enter the Procedure Code(s) and Units:
- Input the relevant CPT/HCPCS codes.
- Specify the number of units (e.g., visits, days, treatments).

3. Click Add to include the procedure details in your request.

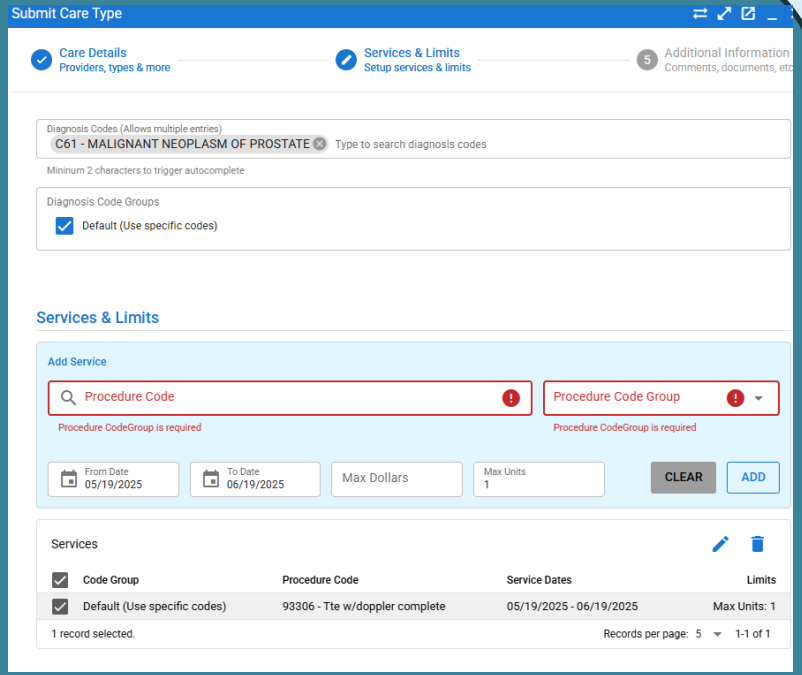
Attach Medical Records & Review

1. Attach Supporting Documentation:
- Upload medical records, referrals, test results, or any clinical notes required to support the request.
- Accepted formats typically include PDF, DOC, or scanned image files.

2.Review All Entered Information:
- Double-check all sections including member details, dates, care type, provider information, diagnosis, and procedures.
- Confirm that the correct documents are attached.

3.When everything is complete, click Finish to submit the prior authorization request.

Final Tip: Submitting a complete and accurate request helps avoid delays in processing or requests for additional information.



Viewing Claims in CIM

You can view a member's claims directly from the **CIM (Care Integration Management) Dashboard** using either **Member Search** or **Claim Search**.

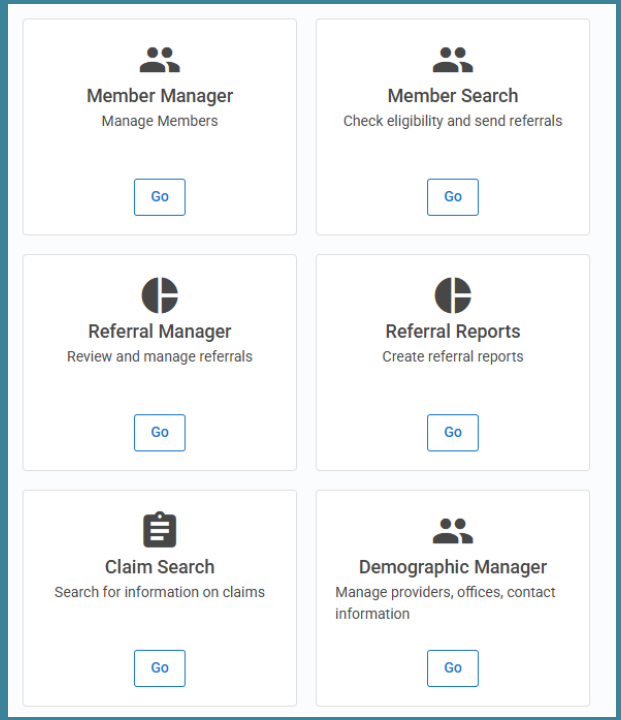
Option 1: View Claims via Member Search

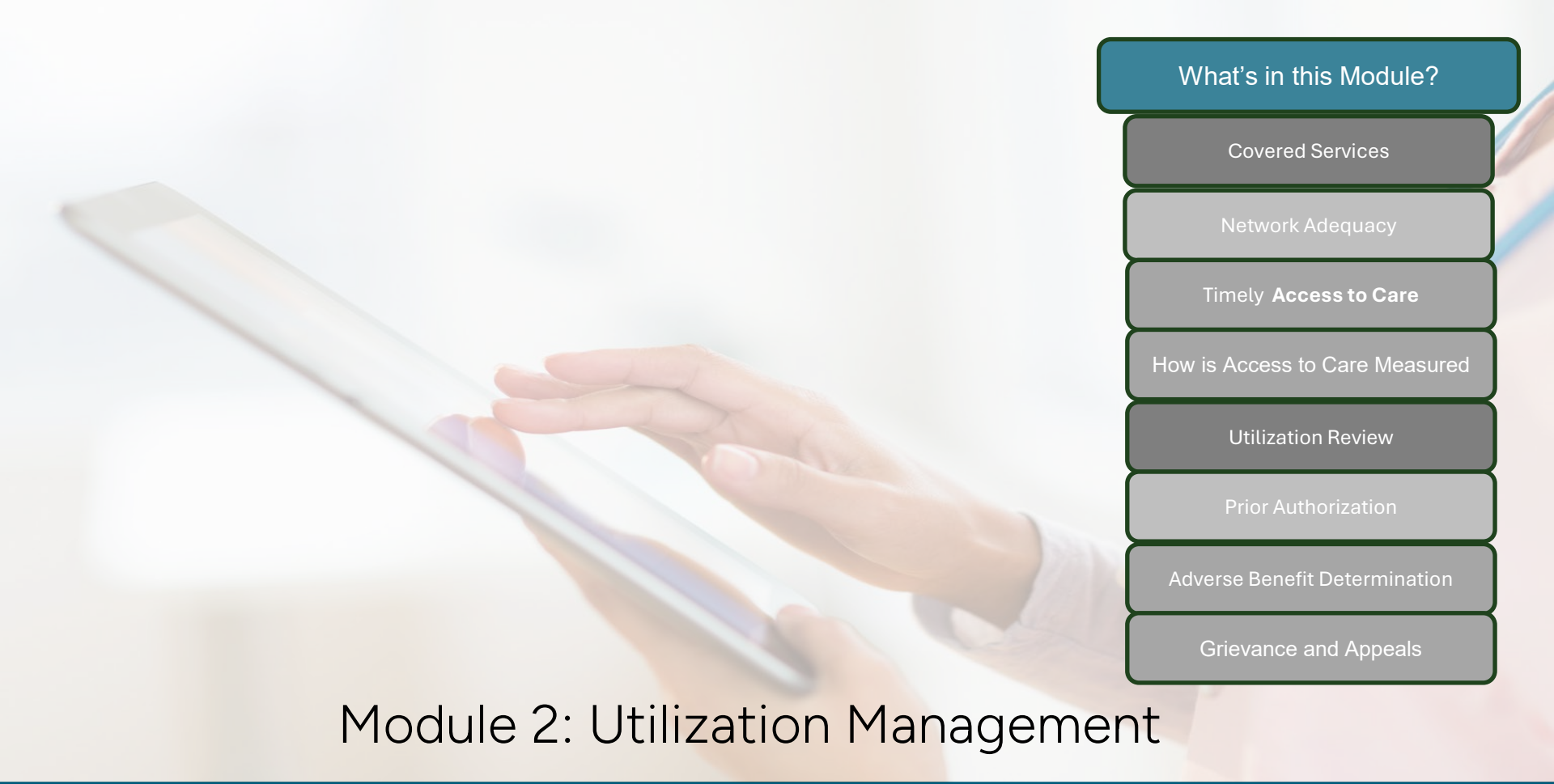
1. From the **CIM Dashboard**, select **Member Search**.
2. Enter the member's:
    1. **Name,**
    2. **Date of Birth (DOB)**, or
    3. **Member ID**
3. Click **Search**, then select the correct patient from the search results.
4. Once in the member's profile, click on the **Claims** tab located on the top banner.

You will now be able to view all claims associated with the selected member.

Option 2: View Claims via Claim Search

1. From the **CIM Dashboard**, select **Claim Search**.
2. Enter search criteria such as:
    1. **Claim number**,
    2. **Date of service**,
    3. **Provider name**, or
    4. **Member information**
3. Click **Search** to view claim details directly.





What's in this Module?

- Covered Services
- Network Adequacy
- Timely **Access to Care**
- How is Access to Care Measured
- Utilization Review
- Prior Authorization
- Adverse Benefit Determination
- Grievance and Appeals

Module 2: Utilization Management

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Covered Services

Accessible	Services covered under the State plan are available and accessible to members.
Timely	All providers must meet OHP standards for timely access to services.
Appropriate	Providers must provide culturally and linguistically appropriate services and supports.

Types of covered Services

Provider of choice	Diagnostic Services	Specialists	Pharmacy
Hospital	Vision	Dental	Ancillary services
FBDE	Second Opinion	Family Planning	Women's Care

Link to UHA Covered Services Policy

Network Adequacy

Network adequacy refers to the ability of a health plan to provide enrollees with timely access to in-network providers sufficient in number, geographic distribution, and provider types to ensure that all covered services are accessible without unreasonable delay.

Umpqua Health Alliance is required to ensure services are accessible to members and are required to continually monitor their contracted provider network – including its clinical capacity – to furnish all contracted benefits to members:

- **Network Adequacy may be evaluated using the following criteria:**
  - Provider-to-enrollee ratios for primary care and/or specialty care;
  - Geographic accessibility;
  - Waiting times for appointments;
  - Hours of operation;
  - Volume of technological and specialty services available to meet member needs.

- **If members need a service that is not available locally (within UHA's provider network), OR the member does not have timely access to the contracted services, members must receive assistance in accessing care from providers outside UHA's service area.**

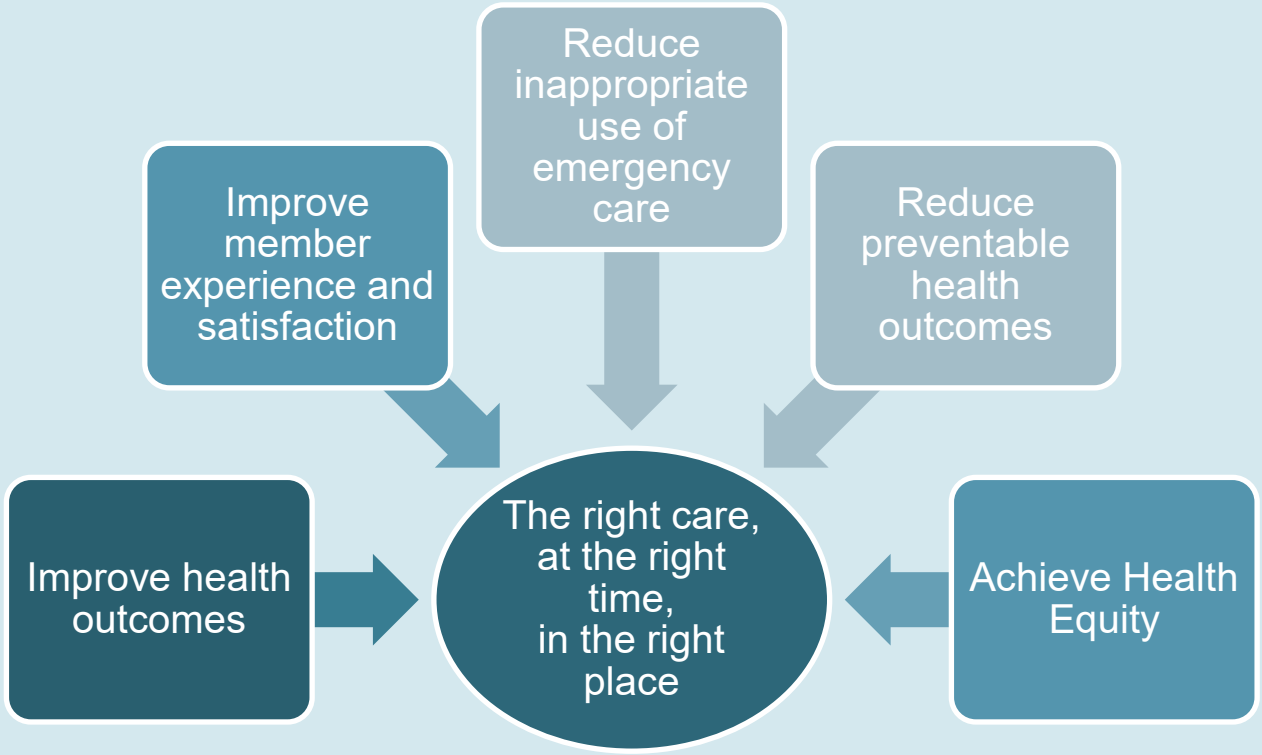
How Does Umpqua Health Alliance Monitor Network Adequacy?

Umpqua Health Alliance (UHA) actively monitors its provider network to ensure members have timely and convenient access to care. Here are the key methods UHA uses:

- **Mandatory Quarterly Access to Care Survey:** Sent regularly to providers to gather feedback on access-related issues. This survey helps UHA evaluate whether there are enough providers across specialties and geographic areas to meet member needs.

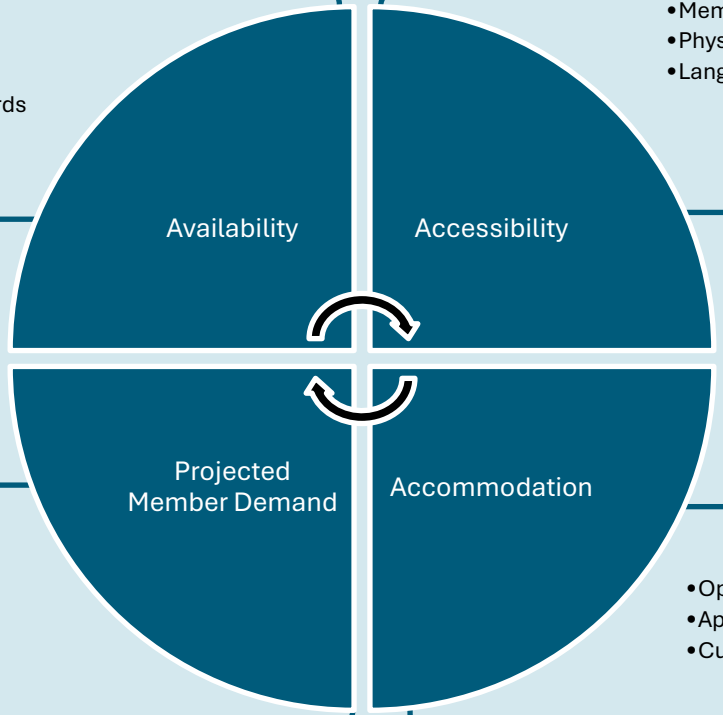
- **Monthly Secret Shopper Phone Calls:** Each month, UHA conducts secret shopper calls to independently verify appointment availability and provider responsiveness. These calls help confirm that providers are meeting access standards in real-world scenarios.

Why is Timely Access to Care Important?



How is Access to Care Measured

- Number of Providers
- Member to provider ratios
- Providers accepting new patients
- Appointments offered meet timely access standards
- Wait Times



- Member travel time and distance
- Physical Access: ramps, parking, rest rooms
- Languages Spoken by Providers

- Count of Members Enrolled
- Expected service utilization: using claims and encounters
- Consideration for Member Characteristics:
  - *Age
  - *Members with FBDE, LTSS, and SHCN
  - *Cultural and Linguistic Needs
  - *Member Experience (CAHPS)

- Operating Hours
- Appointment scheduling
- Cultural and Linguistic Competency

POLICY AND PROCEDURE REQUIREMENTS FOR PROVIDERS

Practices are required to have policies and procedures that ensure appointment scheduling and rescheduling aligns with Oregon Administrative Rule (OAR 410-141-3515)

- **The policies and procedures shall ensure the provision of Oregon certified or Oregon qualified interpreter services anywhere the member is attempting to access care or communicate with the provider/practice**
  - **This includes by phone or in person**
- **Practice procedures must ensure UHA members receive timely follow up when they fail to keep scheduled appointments. This includes contacting members to identify the reason(s) why they failed to keep their scheduled appointment(s) and providing outreach services (where medically appropriate):**
  - **Identify the reason(s) for the missed appointment:**
    - **Due to symptom of their diagnosis and/or disability,**
    - **Due to lack of transportation services (NEMT)**
  - **Assist members with timely rescheduling of their missed appointment(s) as deemed medically appropriate**
  - **Document missed appointments in the clinical record or non-clinical record and include detailed information about:**
    - **Any appointment recall and/or notification efforts**
    - **Method of follow-up**

TIMELY ACCESS TO PHYSICAL HEALTH CARE

APPOINTMENT SCHEDULING

Members must be seen, treated, or referred within the following timeframes for Physical Health services:

Emergency Care:

- Immediately; referred to an emergency department depending upon member's condition

Urgent Care:

- Within 72 hours or as indicated in initial screening

Well Care:

- Within four (4) weeks, or as otherwise required by applicable care coordination rules
  Follow-up visits from ER or post-hospital discharge: within 72 hours

(in accordance with OAR 410-141-3840 & 410-141-3860 through 410-141-3870)

UTILIZATION REVIEW

- UHA provides utilization review in accordance with the policies, procedures, and criteria for covered services that comply with state and federal requirements.
- Reviews ensure medically appropriate, cost-effective health services within the scope of the member's benefit package of health services in accordance with the Prioritized List of Health Services and the terms of the CCO Contract.
- UHA is not structured to provide incentives for the individuals or entities that conduct utilization management activities to deny, limit, or discontinue medically necessary services to any member.
- UHA will not apply more stringent utilization standards to out-of-network services.
- Peer-to-peer consultation is available. For initial or continuing PA requests, a requesting provider can call 541-229-4842, option 3 or email priorauthorizations@umpquahealth.com . Peer-to-peer can occur at the same time a member is in the process of appealing a denial.

PRIOR AUTHORIZATIONS

- Prior authorization (PA) is the determination before a health care service is performed as to whether the requested health care is part of the benefit plan and meets the OHP coverage criteria.
- Routine PA requests should be received by UHA at least two weeks before a planned service is scheduled. This allows time for UHA to process the PA and review pertinent medical information. A copy of the Member's chart notes, lab and/or x-ray tests, and any other pertinent facts should accompany the original request.
- An authorization does not guarantee benefits. The actual claim may be rejected for reasons such as the care provided differs from the care that was pre-authorized. Payment for care that has been pre-authorized will not be denied on the basis of medical necessity unless critical information was not given at the time of authorization (e.g., member was given an experimental or investigational treatment that was not clearly stated in the authorization process). If the Member has lost eligibility, the claim will not be paid, regardless of an approved authorization.

Link to UHA CIM Portal for Eligibility, Claims, & Prior Authorizations

UTILIZATION REVIEW

Authorization Type	Timeline	Urgency
Standard requests	14 days	Standard
Expedite requests - When the standard review timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function in accordance with 42 CFR 438.210(d)(2)(i)	72 hours	Expedite
SUD – Detox & Residential	2 business days	Standard
Skilled Nursing Facility (SNF)	2 business days	Standard
Behavioral Health - Inpatient, PRTS, and Residential Treatment	72 hours	Standard
Timeframe extensions	14 days	Standard/Expedite

Helpful resources
Visit our website at UHA Website to get more information on the PA process. This page contains our PA Grids by service.

Also available to providers is our Utilization Management & Service Authorization Handbook.

☎ **Questions or Need Help?**

Email:
priorauthorizations@umpquahealth.com
Phone: 541-229-4842

Our team is here to assist you!

ADVERSE BENEFIT DETERMINATION

- Adverse benefit determinations are denials, reductions, terminations or failures to provide or pay, in whole or in part, for a benefit.
- Before denying any member treatment for a condition that is below the funding on the Prioritized List of Health Services, UHA Shall determine whether the member has a funded condition/treatment pair that would entitle the Member to treatment under OAR 410-141-3820.
- UHA may place appropriate limits on services:
  - On the basis of criteria applied under the State plan (such as medical necessity).
  - For the purpose of utilization control, provided that:
    - The services furnished can reasonably achieve their purpose.
    - The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need to such services and supports.
    - Family planning services are provided in a manner that enables the member to choose the method of family planning.
- Written notices will be sent to the member and attached to the request in the provider portal for all services that are denied, reduced, terminated, limited, or authorized in a mount, duration, or scope less than what was requested.
  - It must be written in language that is easily understood.
  - It will information about how to appeal the decision.

Adverse Benefit Determinations

Link to42 CFR 438.210

Link to OAR 410-141-3820

GRIEVANCES AND APPEALS

What is a grievance?
Complaint about any matter other than an Adverse Benefit Determination (denial).
Examples: Quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights, regardless of whether remedial action is requested.
Grievances include the member's right to dispute an extension proposed by the UHA to make an authorization decision.

Who can file a grievance?
The member, the member's authorized representative, and/or a provider acting on behalf of a member, with written consent from the member, the legal representative of a deceased member's estate, or UHA (internal staff).

How can grievances be submitted?

Call	Fax	Email	Write or In Person
Phone: 541-229-4842 **Toll free**: 866-672-1551 **TTY**: 541-440-6304	541-677-5881	UHAGrievance@umpquahealth.com	Grievance & Appeals 3031 NE Stephens St. Roseburg, OR 97470 Complaint Form | Spanish

GRIEVANCES AND APPEALS

What is an appeal?
•A request by a member/ authorized representative to review an adverse benefit determination. Members have one level of appeal. Members are required to complete the appeals process before requesting a contested case hearing.

Who can file an appeal?
•The member, the member's authorized representative, and/or a provider acting on behalf of a member, with written consent from the member, the legal representative of a deceased member's estate, or UHA (internal staff).

What is an adverse benefit determination?
•Denial /limited authorization of requested service, including determinations based on the type/level of service, medical necessity requirements, appropriateness, setting or effectiveness of a service (prior authorization)
•Reduction, suspension, or termination of a previously authorized service
•Denial, in whole or in part, of payment for a service
•Failure to provide services in a timely manner pursuant to OAR 410-141-3515
•Failure to act within timeframes provided in OAR 410-141-3875 through 410-141-3895
•For a resident of a rural area with only one MCE, denial of member's request to exercise their legal right under § 438.52(b)(2)(ii) to obtain services outside the network; or the denial of member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other financial liabilities

2025 Member Handbook | 2025 Provider Handbook | Link to OAR 410-141-3515 | OAR Link to OAR 410-141-3875 to 410-141-3915

GRIEVANCES AND APPEALS

Providers' and Subcontractors' Responsibilities

- You must cooperate with all grievance and appeal requirements.
- You may not discourage a member from using any aspect of the grievance, appeal, or hearing process or encourage the withdrawal of a grievance, appeal, or hearing request already filed.
- You may not retaliate against a member or request member disenrollment because of their grievance, appeal, or hearing request.
- You must cooperate with all investigations or requests from the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsperson or hearing representatives, UHA, subcontractors, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes.

Link to OAR 410-120-1860

Link to CCO Contract

Link to 42 CFR 438.4500 to 438.424

GRIEVANCES AND APPEALS

The Grievance and Appeal Process

- Individuals or entities who conduct utilization management activities:
  - Are not provided incentives to deny, limit, or discontinue medically necessary services to any member;
  - Are not involved in other levels of review or the subordinate of someone involved in other levels of review;
  - Have appropriate clinical expertise in treating the member's condition or disease when deciding:
    - An appeal of a denial that is based on lack of medical necessity
    - A grievance regarding denial of expedited resolution for a grievance or service authorization appeal
    - A grievance or appeal that involves clinical issues
  - Will consider all comments, documents, records, and other info submitted by the member/authorized representative, whether info was previously submitted, or for appeals, were considered in the original decision.
- All healthcare information concerning a member's request must be kept confidential, consistent with appropriate use or disclosure as defined in federal, state, and CCO Contract requirements. Assurance of confidentiality must be included in all written, oral, and posted material about the grievance and appeal process.
- A member may be entitled to continuing benefits in the same manner and same amount as previously authorized while an appeal or contested case hearing is pending. Limitations and timeframes must be met for this to be approved.

GRIEVANCES AND APPEALS

Appeal Timelines

If the provider or UHA determines that the standard timeframe may seriously jeopardize the member's life or physical or mental health or ability to attain, maintain, or regain maximum function, UHA will investigate, resolve, and provide notice as expeditiously as the member's health condition requires and within the expedited appeal timeframe.

- Members have 60 days to file an appeal from the date listed on the notice of adverse benefit denial — 60 days
- Oral acknowledgement. Expedited requests are within 1 BD. — 2 business days
- Written acknowledgement. Expedited requests are within 1 BD. — 5 days
- Resolution. Expedited requests are within 72 hours. — 16 days
- Resolution extension — 14 extra days

UMPQUA HEALTH

GRIEVANCES AND APPEALS

Member Hearings

•Hearing requests (standard and expedited) must be filed with the OHA.

•Members, or a participating provider making the request on behalf of a member, can submit hearing requests orally, in writing, or online. When submitted in writing, it must be filed using the Service Denial Appeal and Hearing Request form (OHP 3302) or any other Authority-approved appeal or hearing request form.

•The hearing request must be submitted no later than 120 days from the date of the notice of appeal resolution, when the adverse benefit determination is upheld, or the date that OHA deems that the member has exhausted UHA's appeals process.

•If the member files a request for an appeal or hearing with the OHA prior to the member filing with UHA, OHA shall transfer the request to UHA and provide notice of the transfer to the member. UHA will review the appeal request immediately and respond within 16 days with a NOAR.

What's in this Module?

- Standards for Member Engagement and Member Care
- Care Coordination
- Patient Confidentiality
- Mandatory Abuse Reporting
- ADA and Universal Access

Module 3: Member Engagement

STANDARDS FOR MEMBER ENGAGEMENT AND MEMBER CARE

- Providers are required to offer hours of operation to UHA members that are no less than those offered to commercially insured members or Medicaid Fee For Service (FFS).
- Providers must accept new UHA members unless their practice has closed to new members of any health plan
- Providers must meet the availability standards for appointment times (OAR 410-141-3515).
- Providers may not bill a member, send a member's bill to a collection agency or initiate civil actions against a member to collect money owed by Umpqua Health for which the member is not liable (OAR 410-141-3565).

Link to Provider Newsletter

Link to OAR 410-141-3565

Link to OAR 410-141-3515

CARE COORDINATION

What is Care Coordination?

- Organized coordination of a Member's health care services and support activities and resources. Coordination occurs between two or more people responsible for the Member's health outcomes and includes at least the member and the member's assigned Care Coordinator.

Who is eligible for Care Coordination?

- All UHA members with medical and/or social needs

What assessments and services are available?

- **Assessments available include: Health Risk Assessment (HRA), Case Management Assessment, Prenatal and Post – Partum Assessment**
- **Care Planning**
- **Assistance finding doctors and resources in the community, scheduling appointments, coordinating transitions of care, creating an advance directive, being admitted or discharged from the hospital, and management of condition/symptoms.**

How should providers make referrals?

- https://www.umpquahealth.com/?wpdmdl=14181%27%3ECase%20Management%20Referral%20Form%3C/a%3E **Completed Case Management referral forms can be emailed to case management or faxed to 541-229-8180 or Call 541-229-4842 and ask for Care Coordination.**

Link to Care Coordination Policy

Link to OAR 410-141-3860

PATIENT CONFIEDENTIALITY

- UHA, providers, subcontractors, and business associates are required to comply with federal confidentiality laws and regulations, including HIPAA.
- Providers must provide patients with a Notice of Privacy Practices.
- Providers must respond to patients' requests for:
  - Access to PHI
  - Amendments to PHI
  - Accounting of disclosures
  - Restrictions on uses and disclosures of PHI
  - Confidential communication
- Providers are responsible for safeguarding Members' personal health information (PHI).
- Disclosure of PHI should be limited to the minimum necessary.
- Valid disclosure forms are required prior to the release of PHI as mandated by HIPAA.

Link to OAR 943-014-0015

Link to 42 CFR

Link to UHA HIPAA Training

Link to HIPAA

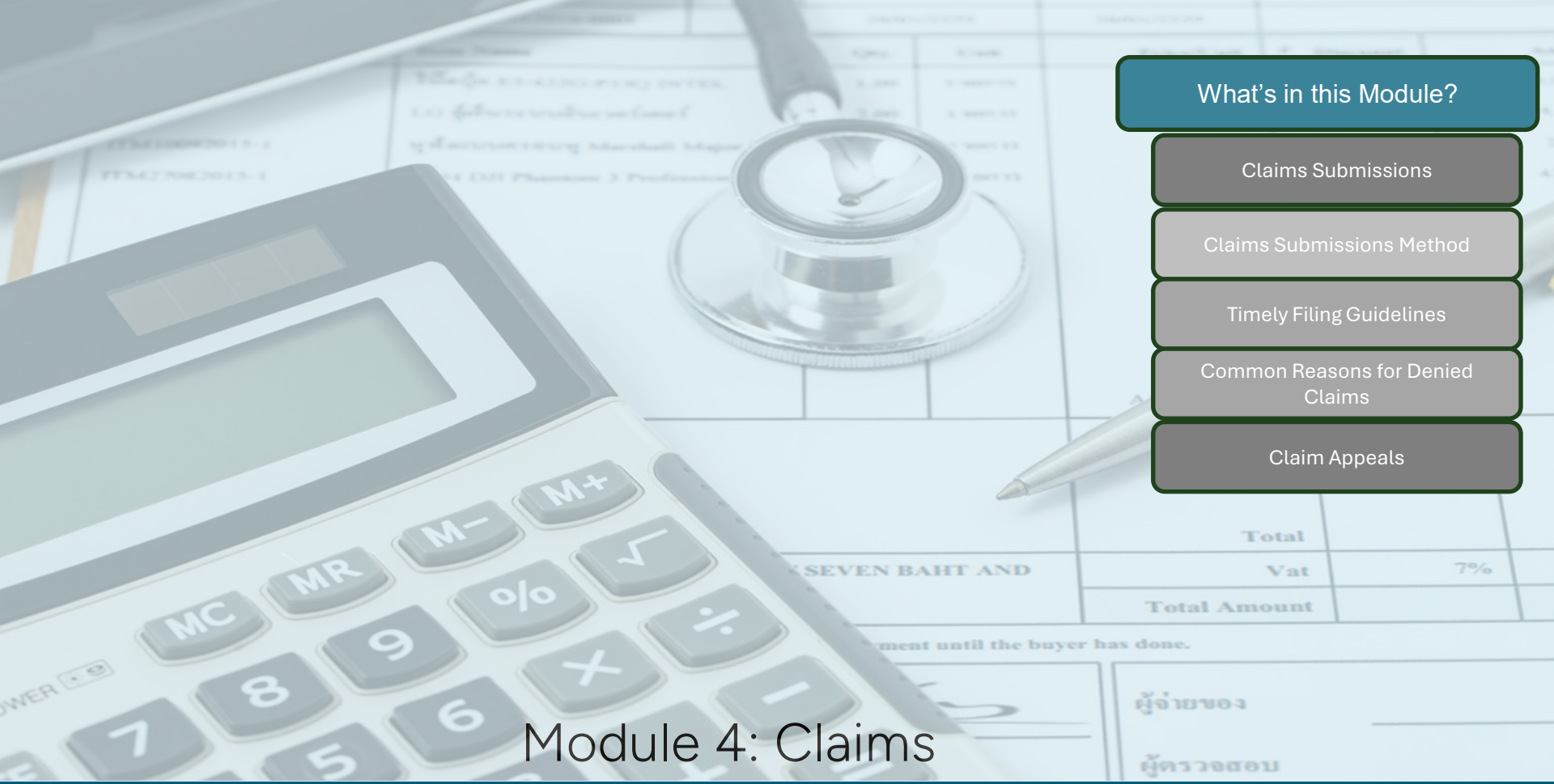
MANDATORY ABUSE REPORTING

- Providers must comply with mandatory abuse reporting requirements, including all protective services, investigation and reporting requirements for:
  - Abuse investigations by the Office of Training, Investigations and Safety (OTIS)
  - Abuse reporting for adults with mental illness or developmental disabilities, including adults receiving services for a substance use disorder or a mental illness in a residential facility or a state hospital
  - Elderly persons and persons with disabilities abuse
  - Residents of long-term care facilities
  - Children in care of a Child-Caring Agency, residential facilities for children with intellectual/developmental disabilities and child foster homes
- Providers must report suspected abuse, neglect, or financial exploitation as follows:
  - To the local county developmental disability program for adults with developmental disabilities
  - To the local county mental health program for adults with mental illness
  - To DHS OTIS for patients of the Oregon State Hospital or residents of Substance Use Disorder treatment facilities;
  - To the local DHS Aging & People with Disabilities office or Area Agency for Aging for elder abuse
  - To the DHS Nursing Facility Complaint Unit for nursing facility residents
  - To the DHS toll-free number 1-855-503-SAFE (7233) for the abuse or neglect of any child or adult

ADA AND UNIVERSAL ACCESS

- Providers are required to comply with the American Disability Act (ADA).
- ADA requires that individuals with disabilities are given full and equal access to health care services and facilities.
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services.

Removing Barries to Health Care: A Guide for Health Professionals



Module 4: Claims

What's in this Module?

- Claims Submissions
- Claims Submissions Method
- Timely Filing Guidelines
- Common Reasons for Denied Claims
- Claim Appeals

UMPQUA HEALTH

Claims Submissions

- UHA accepts paper and electronic claim submissions, and these should be submitted in HIPAA 837P, 837I, CMS 1500, or UB-04 format. In order to be paid for services rendered to a UHA member, provider and or/facility MUST be enrolled with the state of Oregon and have an active DMAP number for the date(s) of service. If you are an out of network provider needing to be enrolled with DMAP, please contact Contracting by phone at (541) 229-4842, option 3 or by email UHAClaims@umpquahealth.com.
- Claims are typically processed within 60 days of receipt of a clean claim. Non-clean claims typically result in a longer adjudication window and/or denials. If you received a claim rejection letter from Ayin, please contact them directly at (503) 584-2169. UHA does not have access to those claims and Ayin will advise on possible solutions.

Facility Type	Claim Form	Billing Rules
Hospital	UB-04	DMAP/Medicare
Physician	CMS 1500	DMAP/Medicare
Federally Qualified Health Clinic (FQHC)	CMS 1500	DMAP/Medicare
All other Claim Types; DME, Lab, Radiology, Transport services, ancillary services	CMS 1500	DMAP/Medicare

Paper Claims

UHA follows requirements set forth by Medicare and OHA for processing of paper CMS 1500 or UB-04 claims. Paper claims must be submitted on either a current standard CMS-1500 form or a UB-04 claim form. When you have important information about a claim, it is best to submit a paper claim with explanations attached. The paper claims and/or documents are converted to electronic image by scanning. The scanned claims then go through an optical character recognition (OCR) process. The following is required in order to properly identify each claim's data:

- CMS 1500 or UB-04 claim forms with red outline that can be scanned should be used. The claim is to be a machine printed with dark black ink. Photocopies, faxes, or handwritten claims will not be accepted. Light ink or dot matrix printed claims may not have characters that are recognized correctly.
- Align the claim form so all information is contained within the appropriate fields. Each piece of data must have a space between it and the next piece of data
- When multiple claim forms are sent, they should each be accompanied by their own EOB, chart notes, and other attachments as needed. DO NOT send multiple claim forms with only one EOB or attachment.
- Each EOB or attachment must be on standard 8.5 x 11 white paper with black print for text only. If the attachment is a screen shot or copy, it must be submitted in color. The images darken upon scanning and may not be readable upon claim review. Half sheets or strips of paper will rip or become separated from the claim in the scanning process. Attachments should not be stapled to the claim
- Additional comments can be made on a standard white sheet of paper and submitted with the claim. Handwriting on the claim will not be picked up during the OCR process.
- Highlighting is not necessary and cannot be seen once the claim is scanned. Use only a yellow highlighter if highlighting is necessary; other colors will scan as black and will not be seen as highlighted material.
- Any EOB attachments must not contain any other patients PHI. Any PHI other than the members should be blacked out. All information included must be for the member the claim is submitted for.

Electronic Claims

HIPAA 837P or 837I claims may be submitted to UHA. EDI claims processing is faster and more cost effective than paper billing. The online software program will pre-process the claim file checking for common billing errors that require immediate attention before the file can be accepted. Most requirements for paper claims also apply to EDI claims. For information on 837P and 837I guidelines, refer to the CMS website at http://www.cms.gov .

If you wish to be set up to send EDI claims online or are having trouble with direct claim submissions, you may contact the PH Tech EDI Support at 503-584-2169, option 1 or email EDI.Support@ayin.com. You can become a direct submitter to PH Tech, or you can use your clearinghouse. If you do not see your clearinghouse on the list below, please reach out to Ayin Tech EDI Support Line above.

Claims Submission Methods

PLEASE MAIL PAPER CLAIMS TO:

AYIN
ATTN UHA Claims
PO BOX 5308
Salem, OR 97304

Please note payer name and address must match as listed or claim may be rejected

ELECTRONIC VENDOR CLEARINGHOUSE	PAYOR ID
Allscripts/ PayerPath (via forwarding)	77502
Availity	77503
Cortex EDI	CIM11
Emdeon/Change Healthcare	77502
GE Healthcare/Athena	77500
Gateway/Trizetto	77504
Office Ally	77501
Relay Health PCS (Professional)	77505-CPID 1291
Relay Health PCS (Institutional)	77505-CPID 6551

Timely Filing Guidelines

Timely Filing Guidelines are as follows:

• 120 days from the date of service (DOS) (unless it is an inpatient stay, then date of discharge)

• 1 year (365 days) from DOS for corrections, appeals, and secondary/tertiary billing (primary EOB/documentation must be included with original claim submission)

Providers are encouraged to submit claims within thirty (30) days of the date of service to facilitate collection of encounter data and provide effective utilization management. Exceptions to the above guidelines for claims submissions are:

- Pregnancy related diagnoses
- When UHA is secondary to Medicare or another third-party resource
- Inpatient stays
- Eligibility issues
- Provider system and/or claim submission errors/issues
- If you are experiencing any system issues with claim submissions or any instances that will delay timely billing, UHA MUST be notified as soon as issue is identified
- Please contact UHA Claims by phone at 541.229.4842 option 2 or by email UHAClaims@umpquahealth.com
- Please note that DMAP enrollment is not a valid reason for untimely claims submission. Once provider/facility becomes enrolled claims are automatically reprocessed and original submission must be within the timely guidelines above

Common Reasons for Denied Claims

- **Member Identification Issues:** Member cannot be identified as a UHA member, often due to mismatches in date of birth, name, or member ID.
- **Timely Filing or Documentation Errors:** Claim filed outside the allowable time frame, duplicate billing , missing or incomplete supporting documentation
- **Provider Enrollment Issues:** Provider or facility is not enrolled with DMAP (Division of Medical Assistance Programs)
- **Multiple Billing Conflicts:** More than one provider or supplier billed on the same claim
- **Coding Issues:** Incomplete or inaccurate coding
- **Improper Claim Form Submission:** Claims not submitted on the correct CMS-1500 or UB-04 form
- **NDC (National Drug Code) Errors :** Missing, incomplete, or invalid unit of measure on codes requiring an NDC
- **Incorrect Provider Information:** Mismatched or invalid provider details
- **Improper Billing of Discarded Drugs :** Discarded medications not billed according to guidelines

Claim Appeals

Providers have up to **one year (365 days)** from the date of service to submit disputes or corrections, provided the initial claim was submitted within the original timely filing guidelines.

Dispute Process

There are **two levels of claim disputes** available if a provider receives a denial or partial payment they disagree with:

Level I Dispute

Level II Dispute

Both levels can be submitted **by mail** or **electronically**. Providers with CIM1 access can also upload Level I or Level II disputes directly to the claim in question via the **provider portal**.

Important Submission Instructions (CIM1 Users)

If you choose to upload a dispute through the provider portal, the following steps are **mandatory** for your submission to be valid:

- **Notify PH Tech via CIM email** immediately after uploading.
- Clearly identify the dispute level in your email subject and body.

Email Guidelines:

- **Level I Disputes:**
  Email subject/title: *Level I Dispute*
  Email to: UHAClaimAppeal@ayin.com
- **Level II Disputes:**
  Email subject/title: *Level II Dispute*
  Email to: UHAClaimAppeal@ayin.com

Failure to send the notification email will result in the dispute being considered **invalid** and **not reviewed**.

Additional Resources

A tutorial on how to upload documentation through the provider portal is available here : How to Upload Addition Documentation / Claims Appeals in CIM

Module 5: Customer Care

What's in this Module?

- PCP Assignment and Reassignment
- Nondiscrimination of Members
- Member Rights and Responsibilities

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PCP Assignment and Reassignment

- UHA members on plan type CCOA and CCOB (who qualify for physical health services) are assigned to an Open PCP upon becoming eligible with UHA. Assignments are made within the first week of enrollment.
  - UHA sends list of newly assigned members weekly to PCPs.
  - Quarterly, a list of all assigned members will be sent to PCPs. PCP should submit corrections to the list within 15 days.
- Providers may contact UHA's Customer Care Department to request a member to be terminated and reassigned to another provider.
  - If UHA approves the termination request, providers are expected to assist in the coordination of care process.
  - The provider office must inform the member by mail of the termination within two business days of the approval.
  - The notification letter should explain the reason for the termination, the timeline, whether the provider is available to see the member during the transition, any refills on prescriptions that will be needed during the transition, any open referrals, name and contact information for the new provider, and the information that the medical record will be available for ten years.

Nondiscrimination of Members

- UHA and its providers must comply with applicable state and federal civil rights laws. People can't be treated unfairly in any programs or activities because of their age, color, disability, gender identity, marital status, national origin, race, religion, sex, sexual orientation, or basis of health status or need for health care services.
- UHA informs its members of this right by providing this information on UHA's website, in the UHA Member Handbook, and along with each grievance and appeals notice. This information can be provided in English and translated into all other prevalent languages upon request.

Nondiscrimination of Members

Members who wish to report discrimination may contact

UHA's Customer Care Department:
Phone: 541-229-4842; Toll Free: 866-672-1551;
TTY: 541-440-6304 or 711;
Fax: 541-677-5881,
Mail: Umpqua Health Alliance
3031 NE Stephens St, Roseburg, OR 97470

UHA's Diversity, Inclusion and Civil Right Executive Manager (Non-discrimination Coordinator):
Phone: 541-229-4842; Toll Free: 866-672-1551;
TTY: 541-440-6304 or 711,
Fax: 541-677-588,
Email: UHAGrievance@umpquahealth.com
Mail: Umpqua Health Alliance,
3031 NE Stephens St. Roseburg, OR 97470
Link to Appeals and Grievances

Oregon Health Authority (OHA) Civil Rights
Phone: (844) 882-7889, 711 TTY ,
Email: **OHA.PublicCivilRights@stater.us**,
Mail: Office of Equity and Inclusion Division,
421 SW Oak St., Suite 750, Portland, OR 97204,
Web: **www.oregon.gov/OHA/OEI** |

Bureau of Labor & Industries Civil Rights Division
Phone: (971) 673-0764,
Email: **crdemail@boli.state.or.us**
Mail: Bureau of Labor & Industries Civil Rights Division
800 NE Oregon St., Suite 1045, Portland, OR 97232

U.S. Department of Health & Human Services
Office for Civil Rights (OCR)
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Email: OCRComplaint@hhs.gov,
Mail: Office for Civil Rights, 200 Independence Ave. SW,
Room 509F, HHH Bldg, Washington, DC 20201

Member Rights and Responsibilities

To view the full list of member rights and responsibilities, please refer to the **Umpqua Health Alliance Member Handbook**

Module 4: Provider Data Management

What's in this Module?

- Credentialing and Recredentialing Process
- Program Oversight and Standards
- Updating Provider Information

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Credentialing and Recredentialing Process

- **Initial Credentialing:**
  All eligible providers must complete the credentialing process and receive **approval by the Credentialing Committee** before delivering care to UHA members.
- **Recredentialing:**
  Recredentialing occurs at least **every three years (not to exceed 36 months to the day)** in accordance with UHA's Credentialing Policies and Procedures.
- **Temporary Participation:**
  Temporary provider participation may be granted **on a case-by-case basis** by the Chairman of the Credentialing Committee or designee.
  - This provisional status **cannot exceed 90 days**.
  - The provider will be formally reviewed at the **next Credentialing Committee meeting**.

UMPQUA HEALTH

Program Oversight and Standards

- UHA's credentialing and recredentialing policies are **reviewed annually** to ensure compliance with:
  - **National Committee for Quality Assurance (NCQA)** standards
  - **CCO Contract** requirements
  - **Oregon Administrative Rules (OARs)** and **Code of Federal Regulations (CRF)**
- Policies may be **updated sooner** if regulatory changes occur.
- The **Credentialing Sub-committee** is responsible for the ongoing review and oversight of the CR Program.
- **All employed and contracted practitioners/providers** are subject to a formal **peer review process** as part of quality assurance and network integrity.

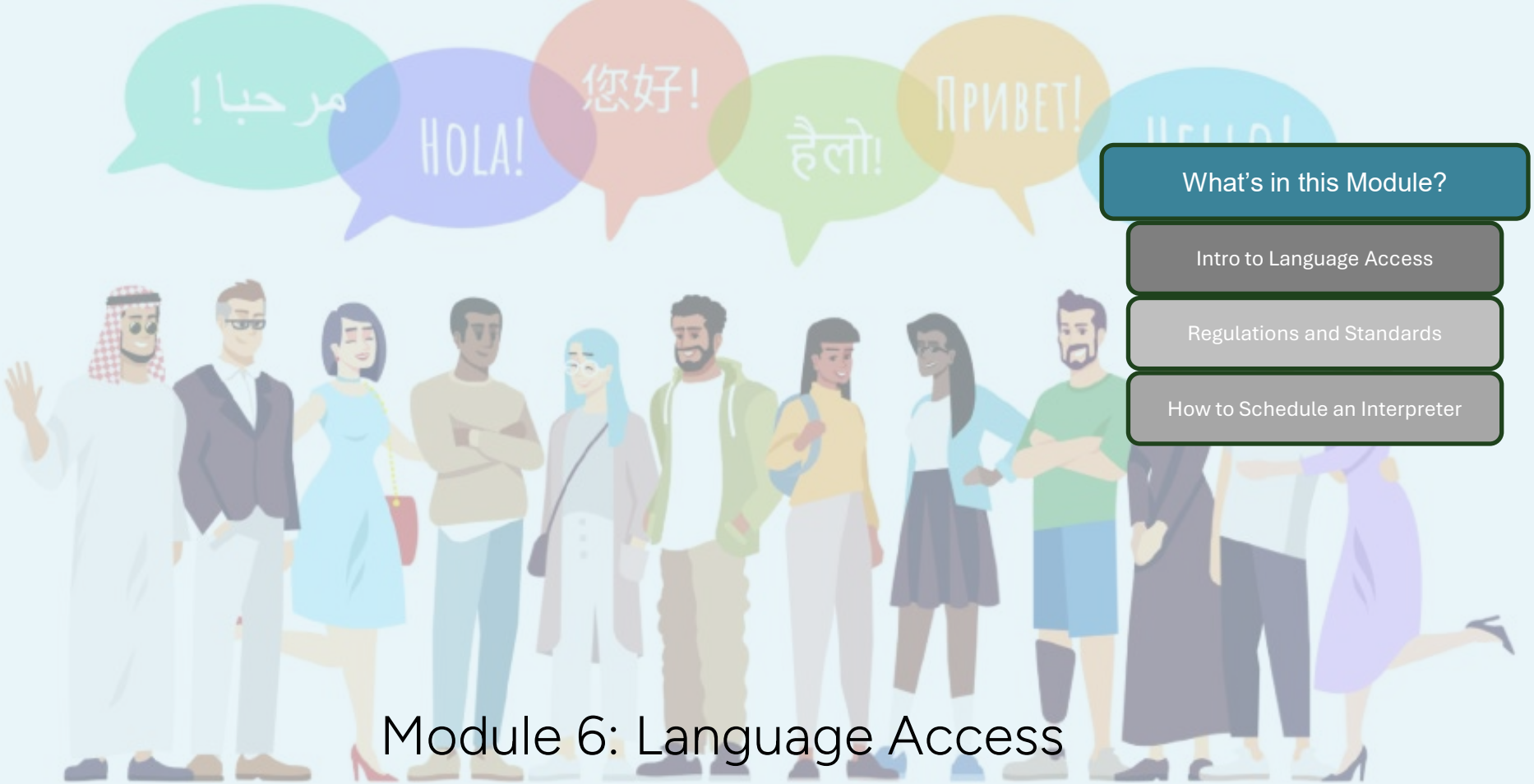
Updating Provider Information

To ensure accurate records and continued network compliance, **providers are required to notify the Provider Relations Department of any changes** to their information.

Steps to Update Provider Information:

1. **Access the Change Forms**
   - Forms can be found here: Provider Forms & Resources
   - **Complete the Relevant Form(s)**
   - Ensure all applicable sections are filled out accurately.
2. **Submit the Forms**

Email the completed forms to:
UHNProviderServices@UmpquaHealth.com



Module 6: Language Access

What's in this Module?

- Intro to Language Access
- Regulations and Standards
- How to Schedule an Interpreter

UMPQUA HEALTH

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Historically, OHP members who speak languages other than English or are hard of hearing have faced significant barriers to accessing healthcare. These challenges often result in lower-quality care compared to English-speaking patients and place individuals at a higher risk for medical errors.

Qualified and Certified Health Care Interpreters (HCIs) play a critical role in reducing health disparities, ensuring effective communication, and improving health outcomes for communities affected by historical and ongoing injustices. By expanding language access, we are working toward a more equitable and inclusive healthcare system for all.

Regulations & Standards

- Civil Rights Act
- The Americans with Disabilities Act (ADA)
- Oregon Administrative Rules (OARs)
- Oregon Revised Statute (ORS)
- National Standards for CLAS

Do *not* use Google Translate!

UHA strives to provide members with culturally and linguistically appropriate services by connecting them with Oregon Qualified or Certified Health Care Interpreters. Do not use Google Translate or bilingual staff who are not Qualified or Certified.

Tell us your concerns in real time!

UHA recognizes the challenges that clinics may face when working with Oregon Qualified or Certified Health Care Interpreters and is committed to supporting solutions. If you encounter a barrier, please notify us immediately so we can help address the issue. Contact us at UHQualityImprovement@umpquahealth.com.

Scheduling **Directly** with UHA Contracted Interpreters

Linguava: Spoken & American Sign Language	• Contact Linguava at (503) 265-8515 or sales@linguava.com to set up a service agreement to begin scheduling directly with the vendor. • 50% Oregon HCI on staff
Oregon Certified Interpreter' Network (OCIN): Spoken Languages & Lesser-Diffusion Languages	• Contact OCIN by email at carlos@oregoncertified.com to set up a free profile and schedule directly with the vendor. • 90% Oregon HCI on staff
All Hands: American Sign Language	• Contact All Hands by phone at (541) 729-7111 to schedule services. • 80% Oregon HCIs on staff – will be 100% by EOY
Ana Garcia: Spanish	• Contact Ana at (541) 537-2553 or anavazquez1980@gmail.com to schedule interpreter services. • 100% Oregon HCIs on staff
Gaby Rosales: Spanish	• Contact Gaby at (541) 530-3752 or Gabyrosales1497@gmail.com to schedule interpreter services. • 100% Oregon HCIs on staff

Scheduling Interpreter Services **Through** UHA

Contact UHA Customer Care at (541) 229-4842 or UHCustomerCare@umpquahealth.com to schedule services with a vendor or interpreter tablet through UHA.

You will need to provide the following information:

- Patient's full name
- Patient's DOB
- Appointment details

How Do I Schedule Interpreter Services?

How to Become a Qualified or Certified HCI

Provider Language Proficiency Requirements

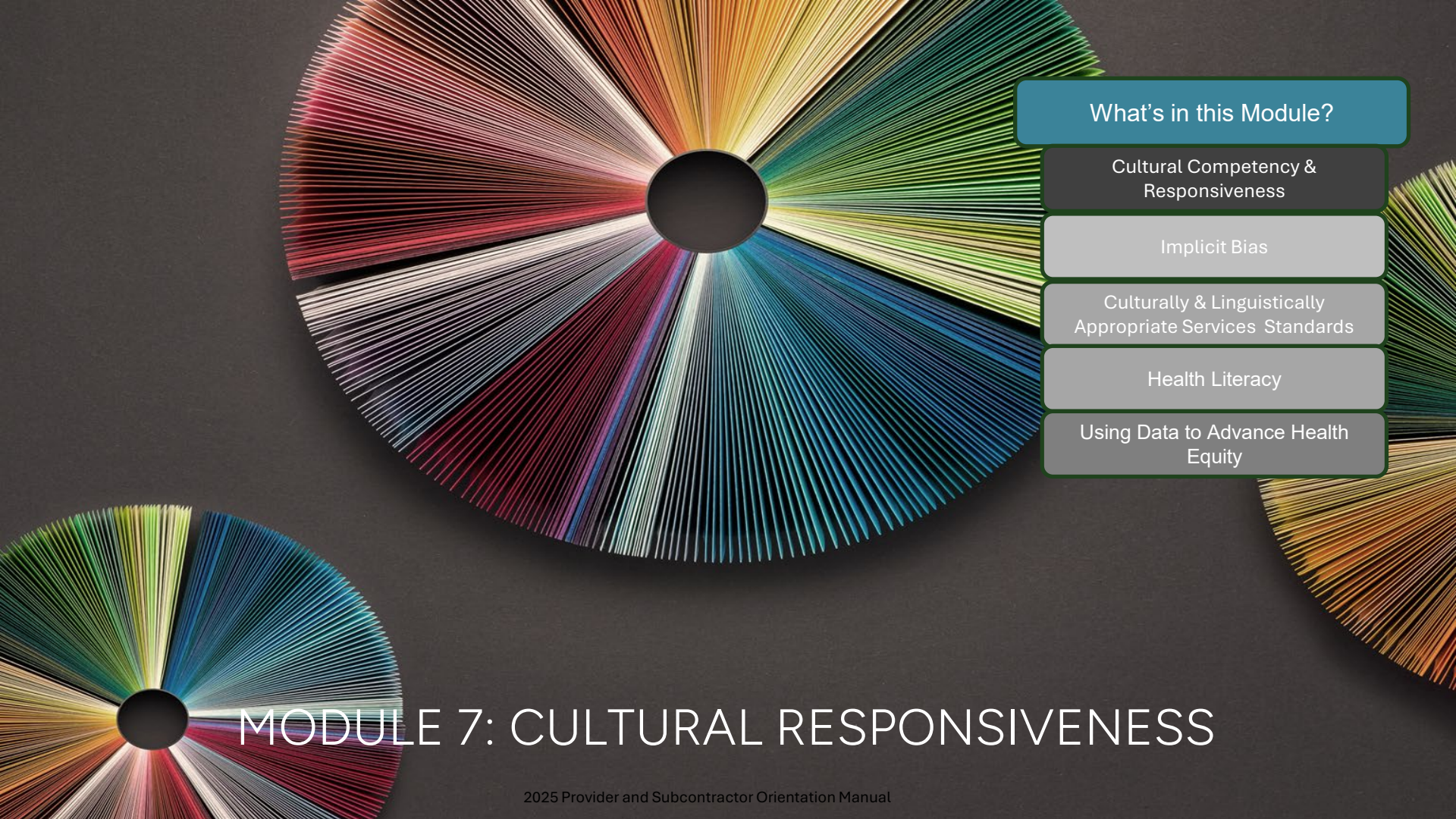
Health Care Interpreter Scholarship

Language Access Resource Binder

Language Access Plan

Language Access Member Poster (top 6 requested languages)

Language Access Member Flyer (English | Spanish)



What's in this Module?

- Cultural Competency & Responsiveness
- Implicit Bias
- Culturally & Linguistically Appropriate Services Standards
- Health Literacy
- Using Data to Advance Health Equity

MODULE 7: CULTURAL RESPONSIVENESS

CULTURAL COMPETENCY & RESPONSIVENESS

- Cultural Competency is defined as “A lifelong process of examining the values and beliefs and developing and applying an inclusive approach to health practice in a manner that recognizes the content and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities.”
- Contracted providers are required to complete a cultural competency training that meets OHA’s Cultural Competency Continuing Education criteria.

Link to Oregon Medical Board’s Guide

Link to OAR 847-008-0077

Link to Board of Licensed Professional Counselors and Therapists Requirements

Link of OHA Cultural Competency Education

Link to Board of Licensed Social Workers Requirements

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IMPLICIT BIAS

- Implicit bias is when an individual has a negative unconscious attitude toward a specific social group (e.g., women or people of a certain race). Even though the individual is not aware of the negative attitude, it can influence the way the individual treats people in that social group.
- When health care providers' implicit bias affect their behavior and decisions for their patients, it can result in lower quality care for their patients and/or reduced patient participation.
- Classes can help reduce the impact of implicit bias and improve patient outcomes.

To University of Oregon Implicit Dias Workshops

UMPQUA HEALTH

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND STANDARDS(CLAS)

- The goal of CLAS standards is to advance health equity, improve quality, and help eliminate health care disparities.
- CLAS is the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- CLAS includes meaningful language access as required by Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services.

Link to National CLAS Standards

Link to National Equity Project

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HEALTH LITERACY

- Health literacy is the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- Using health literacy best practices advances health equity.
- Health literacy best practices includes using plain language, using the individual's preferred language and communication format, and using culturally and linguistically appropriate language.

Link to CDC Guide to Advancing Health Equity

Link to DHS Health Literacy Guide

Behavioral Health

Module 8

UMPQUA HEALTH

Content Overview

- Screening Members
- Trauma-Informed Care
- Motivational Interviewing
- Adverse Childhood Experiences
- ASAM & DSM Criteria
- Wraparound

Screening UHA Members

- Umpqua Health members are not required to obtain approval from a Primary Care Physician to access Behavioral Health Assessment and Evaluation services. All members have the right to self-referral to any behavioral health services within the UHA Provider Network

Umpqua Health members have the right to refer themselves to any behavioral health services in our provider network

Behavioral health assessment and evaluation services do not require approval or referral from a primary care physician

Screening UHA Members

- Umpqua Health requires providers to use a comprehensive Behavioral Health Assessment tool to screen members, in accordance with OAR 309-019-0135.
- Assessments are intended to assist in adapting the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member.

Screen Members for adequacy of supports for the Family in the home: housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting).

Screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have both mental illness and Substance Use Disorders.

Assess for opioid use disorders for populations at high risk for severe health outcomes,including overdose and death, including pregnant members and members being discharged from residential, acute care, and other institutional settings.

Screen for Adverse Childhood Experiences (ACEs) in a culturally and linguistically appropriate manner using a trauma-informed framework.

Screening UHA Members

- As a contracted provider, you are required to screen members to provide prevention, early detection, and brief intervention and referral to behavioral health services in any of the following circumstances:

At an initial contact or during a routine physical exam

At an initial prenatal exam;

When the Member shows evidence of Substance Use Disorders or abuse;

When the Member over-utilizes Covered Services;

When a Member exhibits a reassessment trigger.

Integration and Foundations Trauma-Informed Care

- All Umpqua Health providers are required to be trained in integration and foundations of Trauma-Informed Care.
- Umpqua Health provides regular, periodic oversight, and technical assistance on these topics to providers.
- You may request these supports by contacting behavioralhealthoperations@umpquahealth.com

Trauma-Informed Care Training Resources:

- Trauma-Informed Oregon – Introduction to Trauma Informed Care (TIC) Online Training Modules
- Trauma Informed Care Resources & Guides
- SAMHSA – Trauma-Informed Approaches and Programs
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Motivational Interviewing

- Umpqua Health providers are required to be trained in recovery principles and motivational interviewing.

Motivational Interviewing Training Resources:

- Oregon Alliance – Motivational Interviewing Trainings
- Boost Oregon
- MINT - Motivational Interviewing Trainers in Oregon

ASAM and DSM Criteria

- Umpqua Health providers who assess members for admission to, and length of stay in, Substance Use Disorder and Co-Occurring Disorder programs and services are required to use the ASAM Criteria for all level of care placement decisions.

- These Umpqua Health providers must also possess the training and background necessary to evaluate medical necessity for Substance Use Disorders Services using the ASAM Criteria and DSM Criteria

ASAM and DSM Criteria Training Resources:

- The ASAM Criteria Online Foundations Course
- ASAM E-Learning
- NAADAC – Assessment, Diagnosis, and Treatment of Co-Occurring Disorders and SUD Specialty Online Training Series

Wraparound

- Umpqua Health is required to ensure Behavioral Health Providers are trained in wraparound values and principles as well as a provider's role within a Wraparound child and family team.

Family-Driven and Youth-Guided	• The family and youth, and their needs, direct the types and mix of services received
Strengths-Based	• The strengths of the youth and family are assessed and considered pathways to resolve needs and concerns
Natural Supports	• The team consists of more natural and informal supports than formal service providers. Natural Supports are continuously encouraged and supported
Individualized	• The services and supports are provided based on the needs and strengths of the family, not agency function, menus of services and milieu
Culturally and Linguistically Responsive	• Supports and services build on the preferences, attitudes, beliefs, and culture of the family and youth.
Team-Based	• All decisions are made by the team, not individuals. Families are actively involved in all decisions.
Community-Based	• The supports and services provided mirror that of the community of the family and youth. Every effort is taken to keep the youth in their community.
Collaboration	• All plans are co-authored by the team and family. All decisions are made at the team level.
Persistence	• Specific behaviors do not expel a family from the process. The created plan fails, not the family. Plans are revised at least every 30 days.
Outcome-Based	• All supports and services should be based on what works. Each Wraparound plan should be linked to observable and measurable indicators of success.

What's in this Module?

- Fraud, Waste and Abuse (FWA)
- Anit-Kickback Statute (AKS)
- Stark Law
- False Claims Act (FCA)
- Oregon False Claims Act (OFCA)
- Medicaid Reporting Requirements
- Exclusions, License, Monitoring & Prohibited Affiliations
- UHA Compliance Hotline
- Qui Tam Provision (Whistleblower)
- Exclusion Statue

Module 9: Compliance & FWA Prevention

UMPQUA HEALTH

FRAUD, WASTE, AND ABUSE (FWA)

In the Medicaid program, regulatory measures are established to prevent and detect fraud, waste, and abuse (FWA). As a provider or subcontractor, you serve as a critical line of defense to ensure that neither you nor your organization engage in such activities.

Fraud: When someone intentionally deceives or makes misrepresentations to obtain money or property of any healthcare benefit program.

- Knowingly soliciting, receiving, offering, or paying remuneration, such as kickbacks, bribes, or rebates, to induce or reward referrals for items or service s reimbursed by federal healthcare programs in fraud. Some examples of fraud include:
  - Knowingly billing for services and/or supplies not performed or supplied, for appointments not kept, or for prescription that aren't filled or that don't exist.
  - Knowingly alerting claim forms, medical records, or receipts to receive a higher payment.
  - Using a Medicaid card that is in someone else's name.

FRAUD, WASTE, AND ABUSE (FWA)

- Engaging in fraud is illegal as it violates numerous federal laws that protect government programs.
  - Fraud exposes individuals or entities to potential criminal, civil, and administrative liability and may lead to imprisonment, fines, and penalties.

- Anyone who is a part of the healthcare system can commit fraud.
  - Schemes range from solo ventures to more widespread activities by institutions or group.
  - Fraud can be committed by healthcare providers, suppliers of medical equipment, employees of companies that manage billing, or people with Medicaid.

FRAUD, WASTE, AND ABUSE (FWA)

Waste: The practice that results in unnecessary costs to the Medicaid program.

- This includes overusing services, such as conducting excessive office visits, writing excessive prescriptions or prescribing more medications than necessary for treating a specific condition, or ordering excessive lab tests.

Abuse: Actions taken by a healthcare provider or supplier that directly or indirectly result in an unnecessary cost to the Medicaid program (any healthcare benefit program).

- It is abuse of the system if a person unknowingly bills for unnecessary medical services, bills for brand name drugs when generics are dispensed, charges too much for services or supplies, or misuses codes on a claim.
- Common errors on coding include unbundling or upcoding, which is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

The main difference between fraud and abuse is the level of intention and the knowledge one displays.

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FRAUD, WASTE, AND ABUSE (FWA)

As a Medicaid provider, you are required to do the following to prevent FWA.

- Because your job involves providing health or administrative services to a UHA member (Medicaid), you must comply with all applicable Medicaid requirements, including adopting and using an effective Compliance Program.
- Report any compliance concerns, as well as any suspected or actual violations that you may be aware of.
- Follow your organization's Code of Conduct, including upholding ethics.
- Be knowledgeable about the laws, regulations, and regulations that govern Medicaid fraud and abuse.

FRAUD, WASTE, AND ABUSE (FWA)

Key laws in FWA prevention:

- **The Anti-Kickback Statute (AKS)** makes it illegal to solicit any kind of compensation in exchange for patient referrals for services covered by federal healthcare.
  - This means anything of value, such as free or discounted rent, hotel stays, expensive meals, etc. are illegal to exchange for patient referrals.
  - Violations are punishable by a fine of up to $250,000 and imprisonment up to five (5) years.

There are also guidelines on relationships with different vendors, physicians, and whoever is involved in federal healthcare.

- Any time there's an incentive or reward involved in exchange for something business-related, it is breaking the law.
- This pertains to things like physician recruitment and relationships with the pharmaceutical and medical device industries.

FRAUD, WASTE, AND ABUSE (FWA)

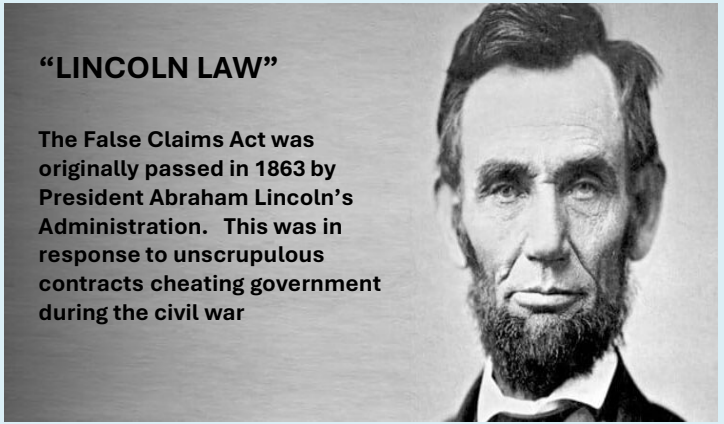
- The **Physician Self-Referral Law**, also known as the **Stark Law**, prohibits healthcare providers from referring clients for designated health services to an organization the physician or their immediate family member has a financial relationship with.
    - Penalties may result in fines upwards of $15,000 for each service provided, plus additional fines.
    - Exceptions may apply. For more information on this please review 42 USC Section 1395nn.

FRAUD, WASTE, AND ABUSE (FWA)

- **The False Claims Act (FCA**) imposes significant civil monetary penalties (CMP) on any person who knowingly submits, or causes someone to submit, a false or fraudulent claim to the federal government they know is false.
  - Any person who knowingly submits a claims they know is false to the government may be liable for three times the damages that are sustained by the government cause by the individual who violated the law plus a penalty. The term “knowingly” can also apply to willful blindness or deliberate ignorance.
  - The CMP may range from $5,500 to $11,000 for each false claim.

- **Criminal Health Care Fraud Statute** violations have fines upwards of $250,000 with imprisonment up to 20 years. If the violations results in death, the individual may be imprisoned for any term of years or for life.
  - In addition to the financial penalties, individuals and entities found in violation may also face exclusion from government programs.

- The State of Oregon has its own version of the False Claims Act, called the **Oregon False Claims Act.** Please watch the video on the next slide.



FRAUD, WASTE, AND ABUSE (FWA)

You are obligated to report any suspected fraud, waste, or abuse. Anytime you think there may be misconduct, report your concerns. Your organization is required to have a way to intake reports of potential FWA and have the option to be anonymous. UHA provides a hotline where providers can make reports of potential FWA and allows for anonymous reporting. Please see the next slide for details.

As mentioned in the previous video, Medicaid requires reporting of FWA to the Oregon Health Authority (OHA). There may also be times where it is necessary to report potential FWA to other government authorities, such as CMS or OIG.

When making a report, it is important to include all relevant contact information and be as detailed as possible regarding the allegations of FWA. If possible, identify the specific Medicaid rules violated, and if known, provide any history of the potential violator, including any education provided, training, and communication your organization may have had or with other entities.

FRAUD, WASTE, AND ABUSE (FWA)

Qui Tam Provision

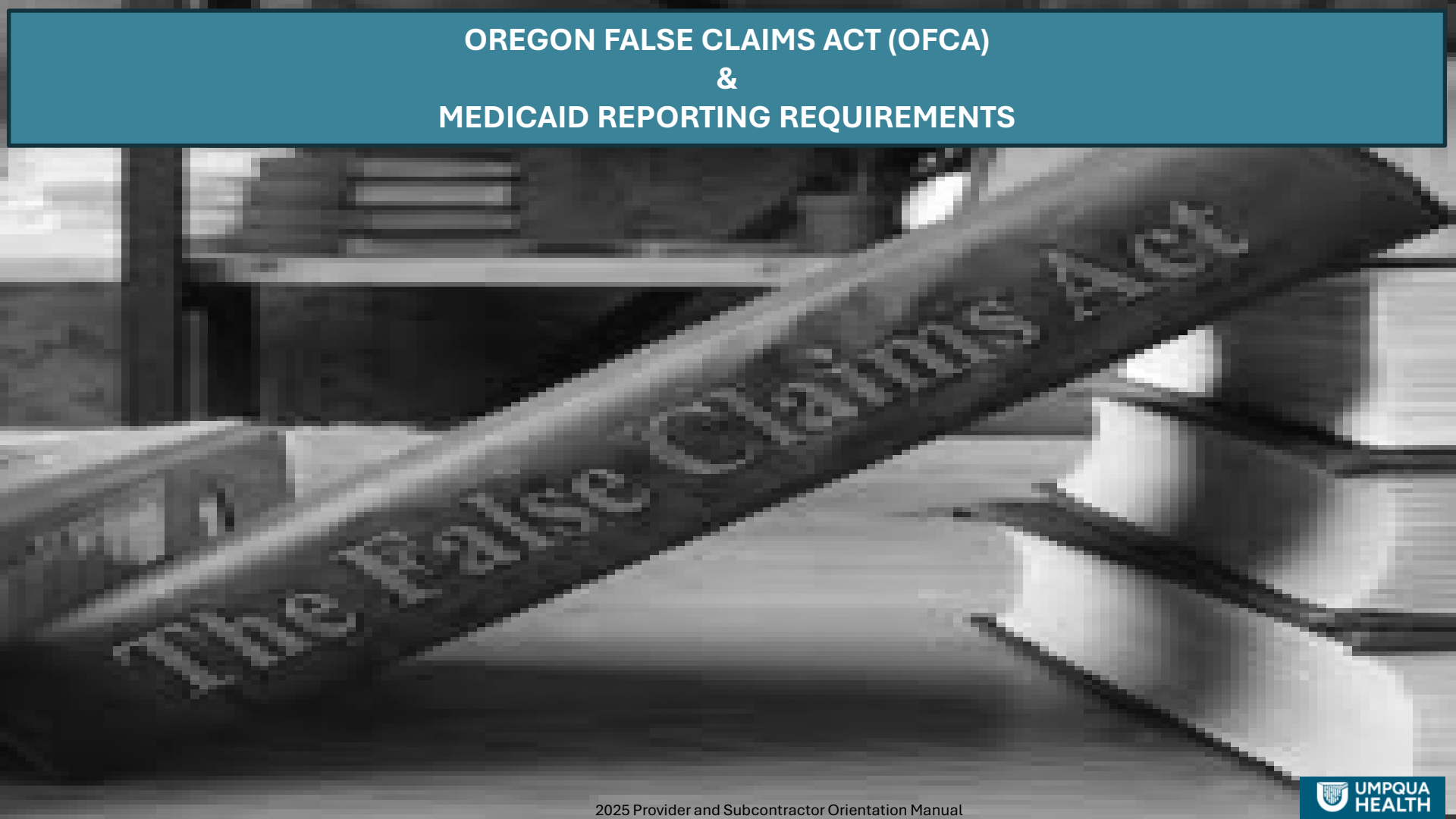
This provision allows private individuals, known as whistleblowers, to file lawsuits on behalf of the government when they have evidence of false claims.

The False Claims Act includes protections for whistleblowers who report in good faith, safeguarding them from retaliation by their employers. Whistleblowers who experience adverse employment actions, such as termination or demotion, as a results of their reporting, are afforded legal protections.

Under the False Claims Act, whistleblowers who bring a successful lawsuit typically receive between 15% and 30% of the recovered funds.

UMPQUA HEALTH

OREGON FALSE CLAIMS ACT (OFCA)
&
MEDICAID REPORTING REQUIREMENTS



UMPQUA HEALTH

Exclusions, License Monitoring, and Prohibited Affiliations

UMPQUA HEALTH

EXCLUSIONS AND PROHIBITED AFFILIATIONS

The Exclusion Statute prohibits individuals with certain offenses, such as Medicaid fraud or submitting fraudulent claims, from receiving federal healthcare dollars.

To comply with federal regulations, UHA is prohibited from certain affiliations with any individual or entity excluded from participation in any Federal health care program under sections 1128 or 1128a of the Act, including the following:

- A director, officer, or partner of UHA.
- A subcontractor of UHA, as specified under section 438.230.
- An individual with beneficial ownership of 5% or more of UHA's equity.
- A network provider or person with an employment, consulting, or other arrangement with UHA for the provision of items and services that are significant and material to UHA's obligations under its CCO contract with the Oregon Health Authority.
- Any individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or non-procurement activities under regulations issued under Executive Order No. 12549 or its implementing guidelines.
- Any individual or entity that is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR Section 2.101, of a person described above.

EXCLUSIONS AND PROHIBITED AFFILIATIONS

Understanding Program Exclusions

What are the different types of exclusions?

- Mandatory Exclusions [42 U.S.C. § 1320a-7(a0]: Office of Inspector General (OIG) is required to exclude the individual or entity for a minimum of 5 years for conviction of certain offenses (e.g. , program-related crimes , patient abuse, felony health care fraud, or felony convictions relating to controlled substances).

- Permissive Exclusions [42 U.S. C § 1320a-7(b)]: OIG may exclude individuals or entities under 16 different authorities (e.g. losing a state license to practice, failing to repay student loans, conviction of certain misdemeanors, or failing to provide quality care).

EXCLUSIONS AND PROHIBITED AFFILIATIONS

Who can be excluded ?

- Any individual or entity.

What is the effect of a program exclusion?

- No payment may be made by any Federal health care program for any items or services furnished, ordered , or prescribed by an excluded individual or entity.
- The prohibition apples to the excluded person, anyone who employs to contracts with excluded person, and any hospital or other provider or supplier where the excluded person provides services. The exclusion applies regardless of who submits the claims and also applies to all administrative and management services furnished by the excluded person.

EXCLUSIONS AND PROHIBITED AFFILIATIONS

How long do exclusions last?

- Certain exclusion are imposed for a defined period, but others may be indefinite in length, such as those derived from licensing board actions.
- Reinstatement is **NOT** automatic. Any individual or entity wishing to again participate in the Medicare, Medicaid, and all Federal Health care programs must apply for reinstatement and receive authorized notice from the OIG that reinstatement has been granted.

How do I check to see if an individual or entity is excluded?

- List of Excluded Individuals and Entities (LEIE): www.oig.hhs.gov/fraud/exclusions.asp
- The Database is downloadable or searchable online by name or business name. Remember to check former names and variations of names.

EXCLUSIONS AND PROHIBITED AFFILIATIONS

- Umpqua Health Management (UHM) is subcontracted by Umpqua Health Alliance (UHA) for the purpose of conducting credentialing and recredentialing activities. UHM, in turn, has subdelegated these activities to Umpqua Health Network (UHN).
- Throughout the credentialing and re-credentialing process, as well as monthly thereafter, UHN conducts exclusion verification checks via a third –party vendor who verifies the Office of Inspector General's List of Excluded Individuals (LEIE), System for Award Management. In addition, UHN also conducts verifications through National Practitioner Data Bank (NPDB).
- If any point during the subcontractor's contract with or a provider's participation in the network it comes to the attention of UHA, UHM, or UHN that a provider or subcontractor has been placed on an exclusions list, the provider/subcontractor contract will be terminated until the exclusion can be cleared with the assigning entity. If the provider can clear the exclusion, the provider is welcome to reapply to the network. A subcontractor may also inquire about delegation possibilities. Furthermore, UHA, its subcontractors, and its first tier, downstream, or related entities (FDR) are required to report within 15 days of a provider's for-cause termination from the network, the exclusion or license notification to the Oregon Health Authority's (OHA) Provider Enrollment.
- In addition, UHN also conducts monthly license and certification monitoring using a third-party vendor, Board licensing reports, and the NPDB. UHA, its subcontractors, and its FDR must report immediately to OHA any provider whose license or certification as expired, has not been renewed, or is subject to sanction or administrative action.

EXCLUSIONS AND PROHIBITED AFFILIATIONS

- UHA members cannot be referred to providers, and UHA may not use providers within its provider network, who have been terminated from OHA, or excluded as Medicare, CHIP, or Medicaid Providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR §1001.101 and 42 CFR § 455.3(b).
- If UHA, its subcontractors, or its FDR knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or State laws under Medicare, Medicaid, or Title XIX (including a plea of “nolo contendere”), UHA, its subcontractors, and its FDR will immediately provide such information to OHA.
- If UHA, its subcontractors, and its FDR are prohibited from engaging in any contract or employment of a provider who has been excluded from participation in Federal health care programs under 42 CFR § 438.214(d), including at State level. This is required under UHA’s Coordinated Care Organization (CCO) Contract with the OHA.
- If UHA, its subcontractors, or its FDR identifies an excluded provider during credentialing, it is required to be reported immediately to HHS-OIG, as required.
- UHA and its Third-Party Administrator Ayin will not accept claims for services provided to UHA members after the date of the provider’s exclusion, conviction, or provider termination.

Ownership Disclosure and Control, Business Transactions, and Information for Persons Convicted of Crimes Against Federal Related Health Care Programs

- **Ownership Disclosures**

- UHA, and its parent company Umpqua Health, are dedicated to ethical and transparent business practices. When entering into an agreement with a subcontractor, as part of its reporting obligations to the Oregon Health Authority (OHA), UHA must disclose any ownership stake between itself and the subcontractor and provide copies of ownership disclosures forms, if applicable. This must be disclosed at the time of contracting to Umpqua Health's Contracting Department.

- To uphold program integrity and transparency in business relationships, UHA has established the following policies in its Compliance Program Manual which serve to describe requirements of:
  - Disclosure of ownership.
  - Disclosures pertaining to business transactions.
  - Disclosure of Ownership Requiring OHA Pre-Approval.
  - Prohibited Affiliations.
  - Disclosure of Information Regarding Crime Convictions

  Link to Compliance Program Manual

COMPLIANCE HOTLINE

Umpqua Health encourages its providers and their staff to report any potential illegal, unethical, or otherwise inappropriate conduct by any person or entity.

To file a report (can be anonymous):
Call (844) 348-4702
Compliance@umpquahealth.com
Submit a report online

Umpqua Health prohibits retaliation of any kind against any person or entity who reports, or assists in the investigation of, any suspected or potential misconduct.

Note: If you know the name of the specific entity involved, please be as detailed as possible with the information provided in your report. After making your report, you will receive a report number that you may use to report additional information or inquire as to the status or resolution of your report. Of note, if you file an anonymous report, please make sure to check in, as additional information may be requested during the investigation.

The company taking the report will pass on employment-related complaints to the Human Resources Department and all other compliance and FWA matters to the Compliance Officer.

Tools and Resources

- Provider Handbook
- Provider Required Trainings
- Subcontractor Required Trainings
- Health-Related Social Needs (HRSN)
- Member Handbook

- Link to sign up for Provider Newsletter
- Provider Update Form
- Provider Termination Form
- Umpqua Health Website
- CIM Portal Instructions 2025
- Zelis FAQ
- Link to Telehealth/ Telemedicine Policy

Umpqua Health Alliance Contacts

- **Provider Relations Department**
  3031 NE Stephens Street
  Roseburg, OR 97470
  Phone: 541-229-4842
  Fax: 541-677-6038
  Email: UHNProviderServices@UmpquaHealth.com

- **Contracting Department**
  3031 NE Stephens Street
  Roseburg, OR 97470
  Email: UHContracting@Umpquahealth.com

- **Compliance Department**
  3031 NE Stephens Street
  Roseburg, OR 97470
  Phone: 541-229-7081
  Email: Compliance@umpquahealth.com

- **Credentialing Department**
  3031 NE Stephens Street
  Roseburg, OR 97470
  Email: Credentialing@UmpquaHealth.com

- **Claims Department**
  AYIN: ATTN UHA CLAIMS
  PO BOX 5308
  Salem, OR 97304
  Phone: 541-229-4842
  Fax: 541-677-6038
  Email: UHAClaims@Umpquahealth.com

UMPQUA HEALTH

Thank You.

UHNProviderServices@umpquahealth.com