CORPORATE POLICY & PROCEDURE

	Policy Name: Covered Services
Department: Clinical Engagement	Policy Number: CE11
Version: 6	Creation Date: 7/1/2016
Revised Date: 5/23/18, 7/30/18, 7/3/19, 7/31/19, 3/1/21	Review Date: 1/22/21
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Signature:  Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 3-12-2021

POLICY STATEMENT

Umpqua Health Alliance (UHA) shall provide to members, at a minimum, those covered services that are medically appropriate and as described as funded condition/treatment pairs on the Prioritized List of Health Services, including ancillary services, as provided for in Oregon Administrative Rule (OAR) 410-141-3830 and as identified, defined and specified in the OHP Administrative Rules and will provide and pay for covered services as required in the (Coordinated Care Organization (CCO) Contract, Exhibit B, Part 2. UHA is required to provide necessary covered services through its provider panel. In the event UHA cannot adequately or timely provide such services, UHA will cover services out-of-network for the member.

PURPOSE

Describe the process UHA will take to ensure its members receive adequate and timely care through the use of covered services, out-of-network providers, and specialty care. In addition, provide reasonable alternatives for members to access care if UHA is unable to provide those services locally.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Health Services: The integrated services authorized to be provided within the medical assistance program as defined in Oregon Revised Statues (ORS) 414.025 for the physical medical, behavioral health that includes mental health and substance use disorders, and dental services funded by the Legislative Assembly based upon the Prioritized List of Health Services.

Non-Participating Provider (i.e. out-of-network): A provider who does not have a contractual relationship with UHA.

Participating Provider (i.e. network provider): A provider who has a contractual relationship with UHA

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PROCEDURES

Covered Services

1. UHA ensures that all services covered under the State plan are available and accessible to members in a timely manner and that UHA provides all covered services specified in the contract and as required by 42 CFR §438.206.
2. UHA shall provide the covered services, including diagnostic services, that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.
3. UHA shall make available to any member, potential member, or participating member, as may be requested from time to time, the criteria for medically appropriate determinations with respect to the benefit package for physical health, behavioral health (which includes mental health and Substance Use Disorders), and oral health to any member, potential member or participating provider, upon request.
4. UHA shall make the health services it provides, including specialists, pharmacy, hospital, vision, dental, and ancillary services, as accessible to members in terms of timeliness, amount, duration, and scope as those services are to non-members within the same service area, which is included in or supports the condition/treatment pairs that are above the funding line on the Prioritized List of Health Services, as provided in OAR 410-141-3830 and OAR 410-141-3300.
5. Except as otherwise provided in OAR 410-141-3820, UHA is not responsible for excluded or limited services as set forth in OAR 410-141-3825.
6. Before denying any member treatment for a condition that is below the funding line on the Prioritized List of Health Services for any Member, including without limitation, disabilities or co-morbid conditions, UHA shall determine whether the member has a funded condition/treatment pair that would entitle the Member to treatment under OAR 410-141-3820 (see policy CE05 – Medical and Pharmacy Review, CE12 – Prior Authorizations, and CE 21- Adverse Benefit Determinations).
7. Except as permitted under Section 1903(i) of the Social Security Act, UHA will pay for organ transplants.
8. UHA is responsible for covered services for Full Benefit Dual Eligibles for Medicare and Medicaid. Contractor shall pay for Covered Services for Members who are Full Benefit Dual Eligibles in accordance with applicable contractual requirements that include CMS and OHA.
9. UHA shall ensure that medical necessity determination standards and any other quantitative or non-quantitative treatment limitations applied to covered services are no more restrictive

than those applied to fee-for-service covered services, as required under 42 CFR §438.210(a)(5)(i).

10. Contractor shall comply with all applicable payment obligations to IHCPs as set forth in 25 USC § 1621e and 42 CFR § 438.14(b)(2) and (c).

Out-of-Network (OON) Services

1. If UHA is unable to provide necessary covered services, including physical health, behavioral health (which includes mental health and substance use disorders), and dental services which are culturally and linguistically and medically appropriate to a particular member within its provider network, UHA will authorize the services with an OON provider using the prior authorization process as outlined in policy CE05 – Medical and Pharmacy Review and CE12 - Prior Authorization, and coordinate payment to with the OON provider to ensure that the cost to the member is no greater than it would be if services were provided within the network.
    a. UHA will not apply more stringent utilization or prior authorization standards to OON services than standards that are applied to medical/surgical benefits, see also policy CE24 – Mental Health Parity for further information.
2. OON second opinions for OON providers require prior authorization as also outlined in policies CE12 - Prior Authorization and CE10 - Second Opinion for Health Care Services.
    a. Providers and members are informed of how to access second opinions via the Provider Handbook and Member Handbook.
3. UHA permits for OON Indian Health Care Providers (IHCPs) to refer a CCO- enrolled Indian member to a participating provider for covered services, as required by 42 Code of Federal Regulations (CFR) § 438.14(b)(4) and (6).
4. At times, UHA's Clinical Engagement department may determine that a single-case agreement (SCA) may be a better solution than individual prior authorizations. Examples include but are not limited to:
    a. Transplant services;
    b. Catastrophic care;
    c. New technology.
5. If it is determined that a SCA is needed, the Provider Network department will complete the SCA for the service negotiated on an individual-patient basis, outlining the agreed upon terms and rates as well as the prohibition against balance billing, except for member coinsurance. Once the agreed upon terms have been finalized, Provider Network will present the final terms to the Chief Medical Officer and Chief Financial Officer, or Chief

Executive Officer, for approval and signature. For more detailed information, see policy CEl7 - Single-Case Agreements.

6. The completed single-case agreement is documented in the claims system and copies are distributed as appropriate by Provider Network.
7. The Clinical Engagement Department will periodically review OON services to determine if there are additional contracting needs, including trends for over and underutilization.

Specialty Health Care Services

1. Prior authorizations (PA) are generally not required for covered services by network providers unless directed otherwise by the Prior Authorization (PA) Grid. These guidelines are outlined and available for members and providers on UHA's website. These may be subject to review as needed to determine medical appropriateness and benefit coverage.
2. Members identified as prioritized population, through eligibility, claims analysis, Health Risk Assessment (HRA) screenings, or referrals, offered intensive care coordination (ICC) services. The care coordinator will assist these members with providing direct access to medically appropriate care for physical health or behavioral health specialist services.
3. UHA provides direct access to women's health specialists within the provider network for covered care necessary to provide routine and preventative health care services for female members. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist.
4. In the event services are not available locally within the UHA network, services will be coordinated with the member's PCP and a non-contracted specialty health care services provider within the most reasonable accessible area.
5. UHA surveys and monitors for equal access of member referrals to provider, pharmacy, hospital, vision, dental, and ancillary services.
6. UHA monitors and evaluates member access in accordance with policy PN9 - Monitoring Network Access.

Department	Standard Operating Procedure Title	Effective Date	Version Number
Clinical Engagement	UM & Service Authorization Handbook	8/9/20	1