CORPORATE POLICY & PROCEDURE

	Policy Name: CE11 - Covered Services
Department: Health Plan Operations	Policy Number: CE11
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Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health Management ☐ Umpqua Health - Newton Creek ☐ Umpqua Health Network	
Approved By: Philip H. Greger Jr., MD, MBA, MLS (Chief Medical Officer) Date: 11/18/2022	

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 OAR Chapter 410 and OAR 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. Umpqua Health Alliance (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 Oregon Administrative Rule (OAR) 410-141-3585 and Exhibit G, Section 2(c)(9)).

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 as described in Coordinated Care Organization (CCO) Contract, Exhibit B, Part 4, Section 4. 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.

Intensive Care Coordination (ICC): Refers to the specialized services described in OAR 410-141-3870. These services have, in other contexts, been labeled Exceptional Needs Care Coordination.

Licensed Medical Practitioner (LMP): A Person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or

designee: Physician, Nurse Practitioner or Physician Assistance, who is licensed in the State of Oregon, and whose training, experience and competence demonstrate the ability to conduct a mental health assessment and provide medication management for; intensive outpatient services and supports, intensive treatment services providers, board-certified or board-eligible child and adolescent psychiatric licensed to practice in the State of Oregon (OAR 309-019-0105).

Non-Participating Provider (Out of Network): A provider who does not have a contractual relationship with UHA.

Participating Provider (In Network): A provider who has a contractual relationship with UHA.

Special Health Care Needs: Individuals who are aged, blind, deaf, hard of hearing, disabled or who have complex medical needs, high healthcare needs, multiple chronic conditions, mental health issues or Substance Use Disorder (SUD) and either have functional disabilities, or live with health or social conditions that place them at risk of developing functional disabilities (serious chronic illness, or certain environmental risk factors such as homelessness or family problems that led to the need for placement in foster care).

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 meet, and require all providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. UHA complies with OAR 410-141-3515 and 410-141-3860. UHA will make all covered services available twenty-four (24) hours a day, seven (7) days a week, when medically appropriate.
3. UHA shall provide culturally and linguistically appropriate services and supports in locations as geographically close as possible to where members reside or seek services. UHA shall also provide a choice of providers (including physical health, behavioral health, providers treating substance use disorders, and oral health) who are able to provide culturally and linguistically appropriate services within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.
4. 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.
5. 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), oral health or other services to any member, potential member or participating provider, upon request as outlined in OAR 410-141-3515 (9).

6. 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 410-141-3820 through OAR 410-141-3830.
7. 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.
    a. UHA will offer our members, at a minimum:
        i. The physical, behavioral and/or oral health services covered under the member's benefit package, as appropriate for the UHA's mandatory scope of services; and
        ii. Any additional services required in OAR chapter 410, or in the CCO Contract.
8. 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 – Utilization Review, CE12 – Prior Authorizations, and CE 21-Adverse Benefit Determinations).
9. Except as permitted under Section 1903(i) of the Social Security Act, UHA will pay for organ transplants.
10. UHA is responsible and shall pay for covered services for Full Benefit Dual Eligible members in accordance with applicable contractual requirements that include CMS and OHA.
11. 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).
12. 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).
13. UHA will not deny covered services to, or request disenrollment of, a member based on disruptive or abusive behavior resulting from symptoms of a mental or substance use disorders or from any other disability. UHA has developed appropriate treatment plans with such members and their families or advocates to manage such behavior, see CE16 – Intensive

Care Coordination, CE18 – Integrated Care Coordination, CE26 - Behavioral Health Screening, Care Coordination/ Intensive Care Coordination and Reporting.

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 oral health or other services which are culturally and linguistically and medically appropriate to any member, potential member, or participating member within our provider network, UHA will authorize the services with an OON provider using the prior authorization process as outlined in policy CE05 – Utilization Review and CE12 - Prior Authorizations, 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 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 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 authorization is not required for outpatient office visits for UHA contracted medical and behavioral/mental health specialists, pharmacy, vision, dental, and other select ancillary services.
2. UHA maintains a prior authorization list for select health care procedures which may be subject to review to determine medical appropriateness and benefit coverage.
3. The UHA prior authorization grid is available on the UHA website or through contacting Customer Care.
4. Members may be identified through eligibility and claims analysis as members with special health care needs, severe persistent mental illness (SPMI) and or chronic complex conditions. These members will be offered intensive care coordination (ICC) services.
5. The case manager will assist with providing direct access to medically appropriate care for physical health, oral health or behavioral health specialist services. UHA allows direct access to specialty care for members with special health care needs and severe persistent mental illness, in accordance with Standard Operating Procedure (SOP-CE15/CE16/CE18-09) Special Health Care Needs.
6. 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.
7. 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 service provider within the most reasonable accessible area.
8. UHA surveys and monitors for equal access of member referrals to provider, pharmacy, hospital, vision, dental, and ancillary services.
9. UHA monitors and evaluates member access in accordance with policy PN9 – Monitoring Network Access.
10. UHA will ensure provider and staff have training in recovery principles, motivational interviewing, integration, and foundation of trauma.
11. UHA will ensure employees, subcontractors and providers are trained in integration, and Foundations of Trauma Informed Care.
12. UHA will ensure that employees or providers who evaluate members for access to, and length of stay in substance use disorders programs and services use the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance related disorder, second edition-revised (PPC-2R) for level of care placement decisions, and that they have the training and background necessary to evaluate medical necessity for substance use disorder services using ASAM.

13. UHA recognizes Oregon Health Authority's (OHA) licensing standards for mental health and substance use disorder programs as the minimum necessary requirement to enter the provider network.
14. UHA will periodically inform all participating providers of the availability of intensive care coordination (ICC) services, providing training to Patient-Centered Primary Care Home (PCPCHs) and other Primary Care Practitioner (PCPs) staff regarding intensive care coordination screenings and services and other support services available to members.
15. UHA will maintain records documenting academic credentials, training received, licenses or certification of staff and facilities used, and reports from the National Practitioner Data Bank and will provide accurate and timely information about license or certification expiration and renewal dates in the Delivery System Network (DSN) provider Report required to be made in accordance with, Exhibit G of CCO Contract.
16. UHA will provide OHA with an Annual Training and Education Report that documents all of the previous contract year's training activities that were provided to its employees, including, without limitation, reporting of training subjects, content outlines and material, assessments of goals and objectives, target audience, delivery system evaluations, training dates and hours, training attendance and trainer qualifications.

Department	Standard Operating Procedure Title	Effective Date	Version Number
Health Plan Operations	UM & Service Authorization Handbook	8/9/20	1
Health Plan Operations	Special Health Care Needs	SOP-CE15/CE16/CE18-09	1