# WELCOME TO UMPQUA HEALTH ALLIANCE

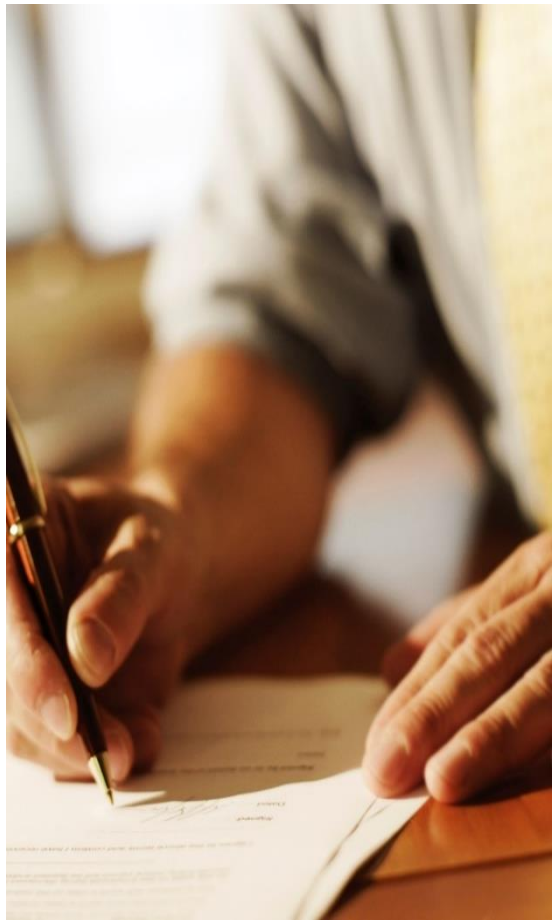
## 2024 ORIENTATION & TRAINING MANUAL

### PROVIDERS AND SUBCONTRACTORS

# TRAINING OVERVIEW

This manual was designed to be a tool to help you understand your responsibilities and UHA's expectation of contracted provider(s), facility(ies), and/or subcontractor(s) and where to locate and find information about UHA processes and policies.

- Newly employed staff should be provided this manual 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.

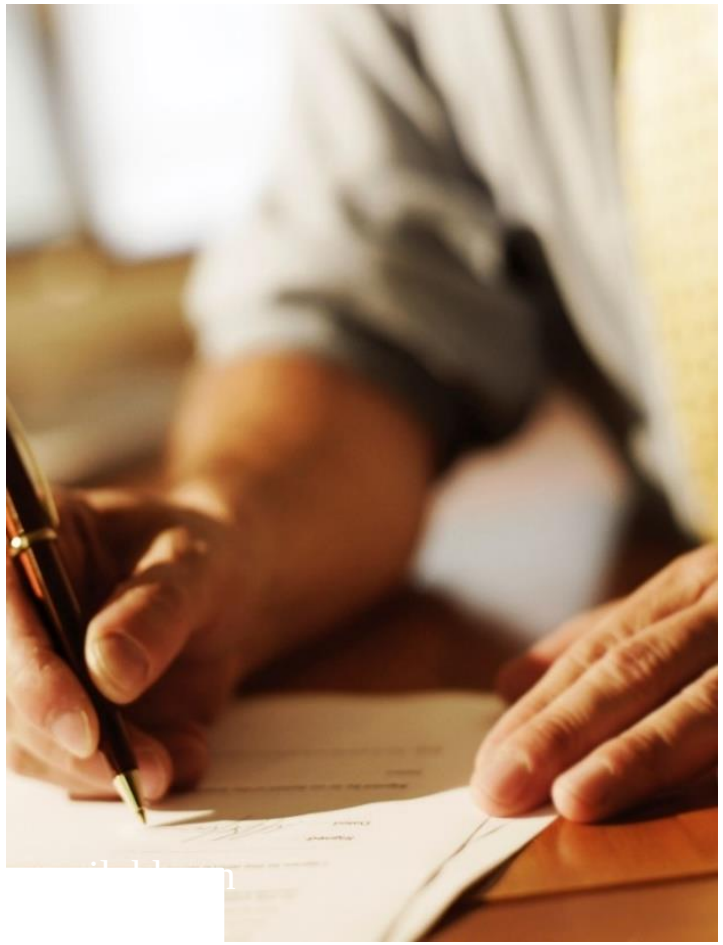


UHA's policies and Provider Training resources are available on UHA's website:
https://www.umpquahealth.com/provider-trainings/
The policy explain the process of the provider and subcontractor training is available at:
https://www.umpquahealth.com/?wpdmdl=14049%27%3EPN6%3C/a%3E

# TRAINING OVERVIEW

## Accessibility

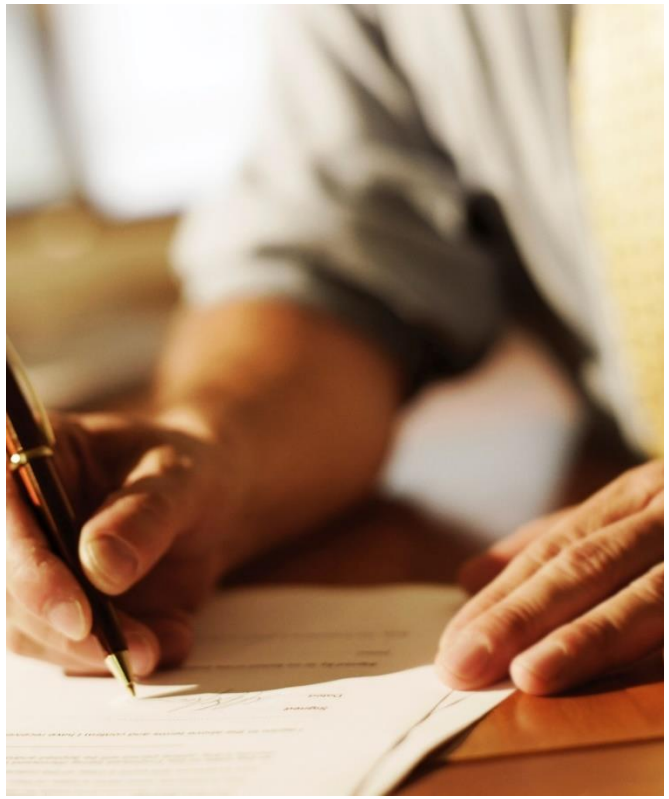
This information is available in other formats, including extra large font, other languages, and an oral version. To request an alternative format, please contact uhnproviderservices@umpquahealth.com.



# TRAINING OVERVIEW

Introduction to Oregon Health Plan, CCOs, and Umpqua Health Alliance

| | |
|---|---|
| Module 1: | Cultural Responsiveness |
| Module 2: | Provider Network |
| Module 3: | Member Engagement |
| Module 4: | Medical Management |
| Module 5: | Customer Care |
| Module 6: | Recovery |
| Module 7: | Compliance & FWA Prevention |



- What's in the Introduction?
- What is a CCO?
- What is OHP?
- What is UHA?

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

# INTRODUCTION TO CCOS AND 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.

Umpqua Health Alliance (UHA) is one of Oregon's 16 coordinated care organizations (CCOs).

We have been providing our members with Oregon Health Plan benefits since 2012.

We have more than 40,000 members in our service area, which includes most of Douglas County.

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.

We encourage health system transformation and strive to improve health outcomes, increase member satisfaction, and reduce overall costs of healthcare.

UHA is managed through a board of directors and Community Advisory Council Members that are based in our community.

Our governance structure helps ensure accountability and partnership in addressing local healthcare needs.

## Our Mission

- Promote and provide high quality, readily accessible healthcare in a patient-centered system of care for the members we serve.

## Our Values

- Accountability
- Efficiency
- Be a Team Player
- Integrity
- Stewardship

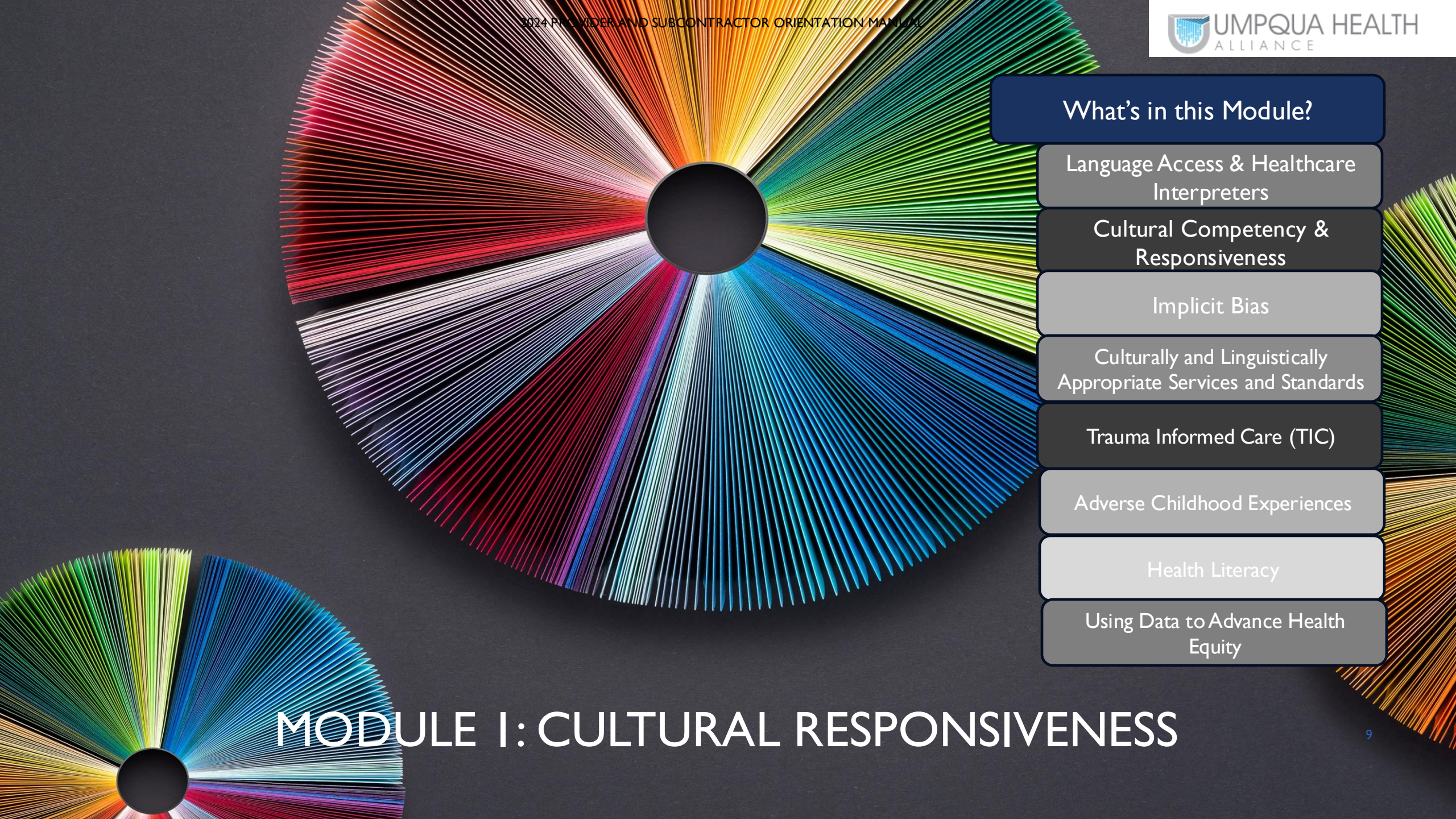
## Agreements

- Clear about our purpose before we act.
- Present and engaged with one another as we work.
- Real and authentic in our communication.
- Connected through being kind and caring.
- Creative and innovative individually and collectively.

## Health Equity

- UHA's mission works to achieve health equity for all population groups by allocating resources towards designing policies and programs to create greater social justice in health.

UMPQUA HEALTH ALLIANCE



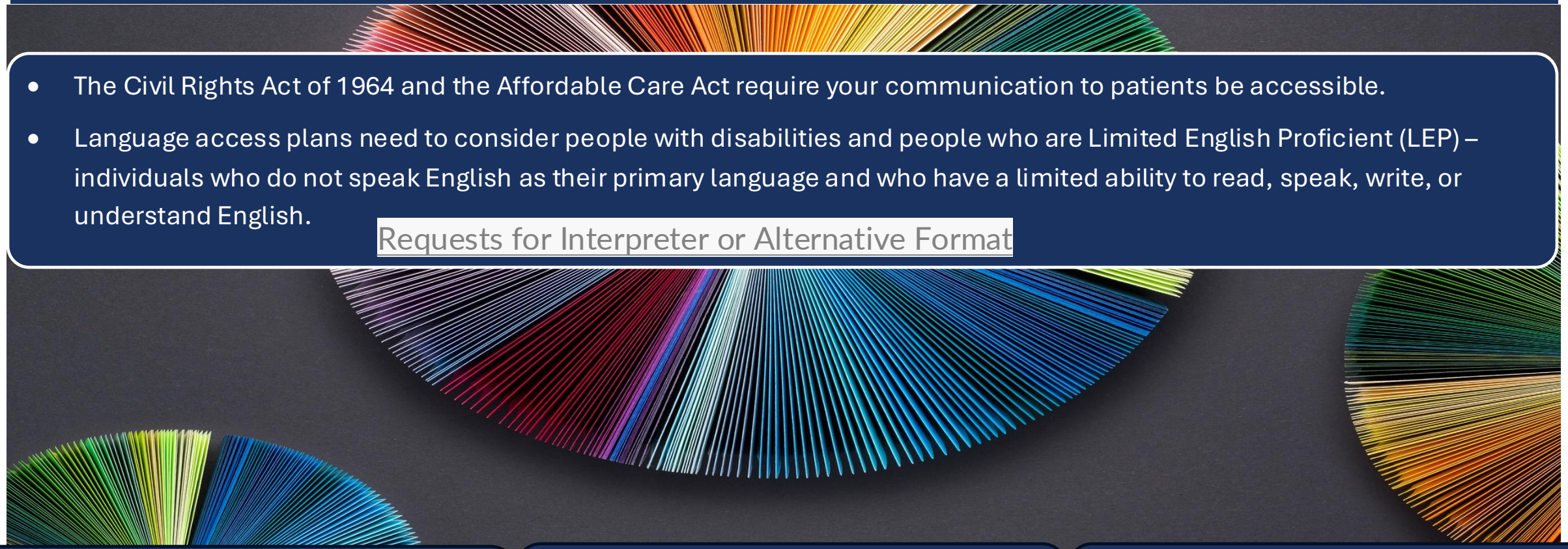
## What's in this Module?

- Language Access & Healthcare Interpreters
- Cultural Competency & Responsiveness
- Implicit Bias
- Culturally and Linguistically Appropriate Services and Standards
- Trauma Informed Care (TIC)
- Adverse Childhood Experiences
- Health Literacy
- Using Data to Advance Health Equity

# MODULE 1: CULTURAL RESPONSIVENESS

UMPQUA HEALTH ALLIANCE

# LANGUAGE ACCESS & HEALTHCARE INTERPRETERS



- The Civil Rights Act of 1964 and the Affordable Care Act require your communication to patients be accessible.
- Language access plans need to consider people with disabilities and people who are Limited English Proficient (LEP) – individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Requests for Interpreter or Alternative Format

*Link to Guidelines for Medical Interpreter Services:* https://www.aamc.org/media/24801/download

*Link to Interpreter Requirements:* https://www.oregon.gov/omb/topics-of-interest/pages/health-care-interpreter-requirements.aspx

*Link to Language Access Presentation:* https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/august-2022-improving-health-underserved-populations.pdf

# LANGUAGE ACCESS & HEALTHCARE INTERPRETERS

- Health care providers who are reimbursed with public funds are now required to work with health care interpreters certified by the Oregon Health Authority (OHA).
- There are some exceptions provided in the rules:
  - The health care provider is proficient in the preferred language of the person with limited English proficiency.
  - The person with limited English proficiency has an interpreter they prefer to work with who is not on OHA's registry (such as a family member).
  - The health care provider tried to find an interpreter using OHA's registry, but no interpreters were available.
- The law also lays out recordkeeping requirements for health care providers and interpreting services companies when they work with a health care interpreter.

*Link to OHA Interpreter Registry:*

https://hciregistry.dhsoha.state.or.us

*Link to OHA Guidance:*

chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https:/www.oregon.gov/oha/Documents/licensing/OCHCI Guidance Document for Compliance with GFE Requirements.pdf

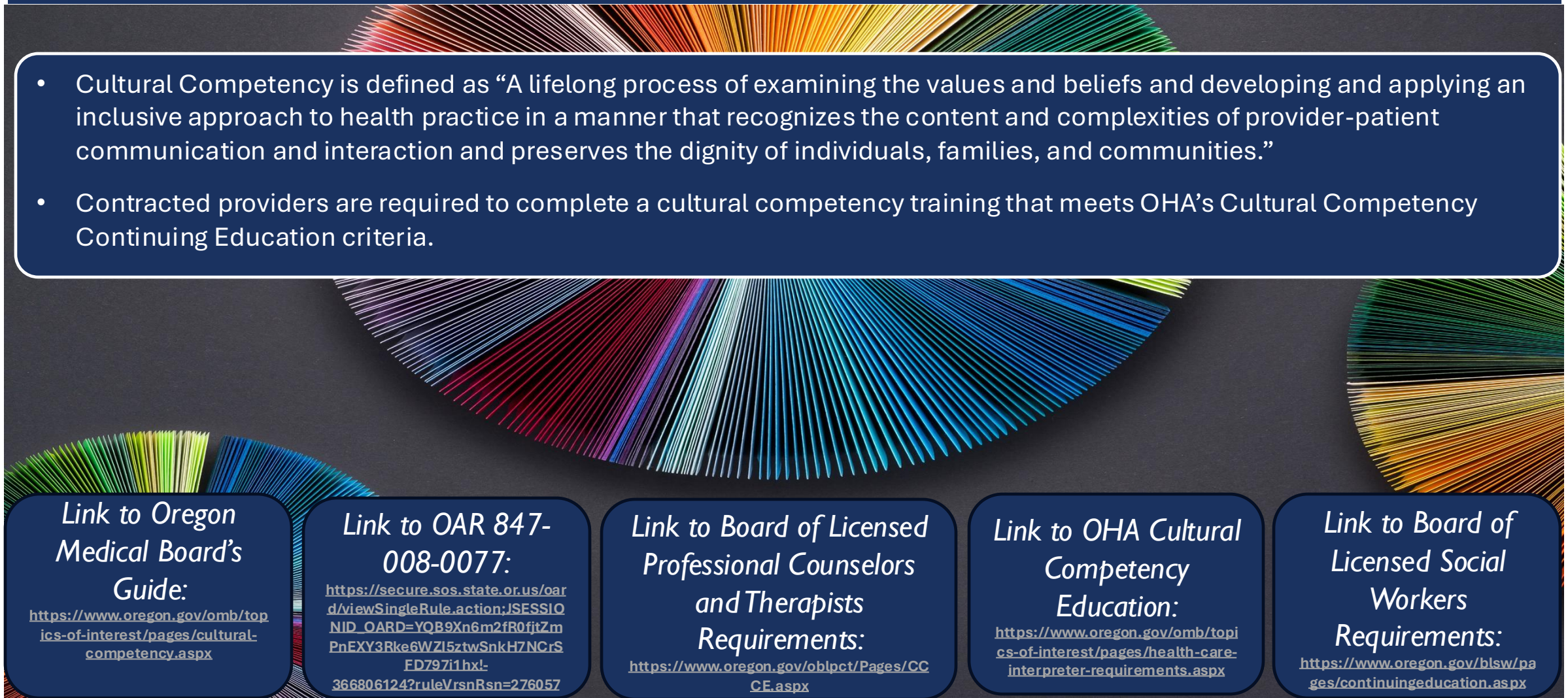
*Link to OAR 333-002-0250:*

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300481

*Link to OAR 847-010-0140:*

https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=cA6JZIRerhcO6ZvPQRB53tAj74NPWiY6mA3fuQUjoO4DcWNHdWom!1961848273?ruleVrsnRsn=294597

# 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:*
https://www.oregon.gov/omb/topics-of-interest/pages/cultural-competency.aspx

*Link to OAR 847-008-0077:*
https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=YQB9Xn6m2fR0fjtZmPnEXY3Rke6WZl5ztwSnkH7NCrSFD797i1hx!-366806124?ruleVrsnRsn=276057

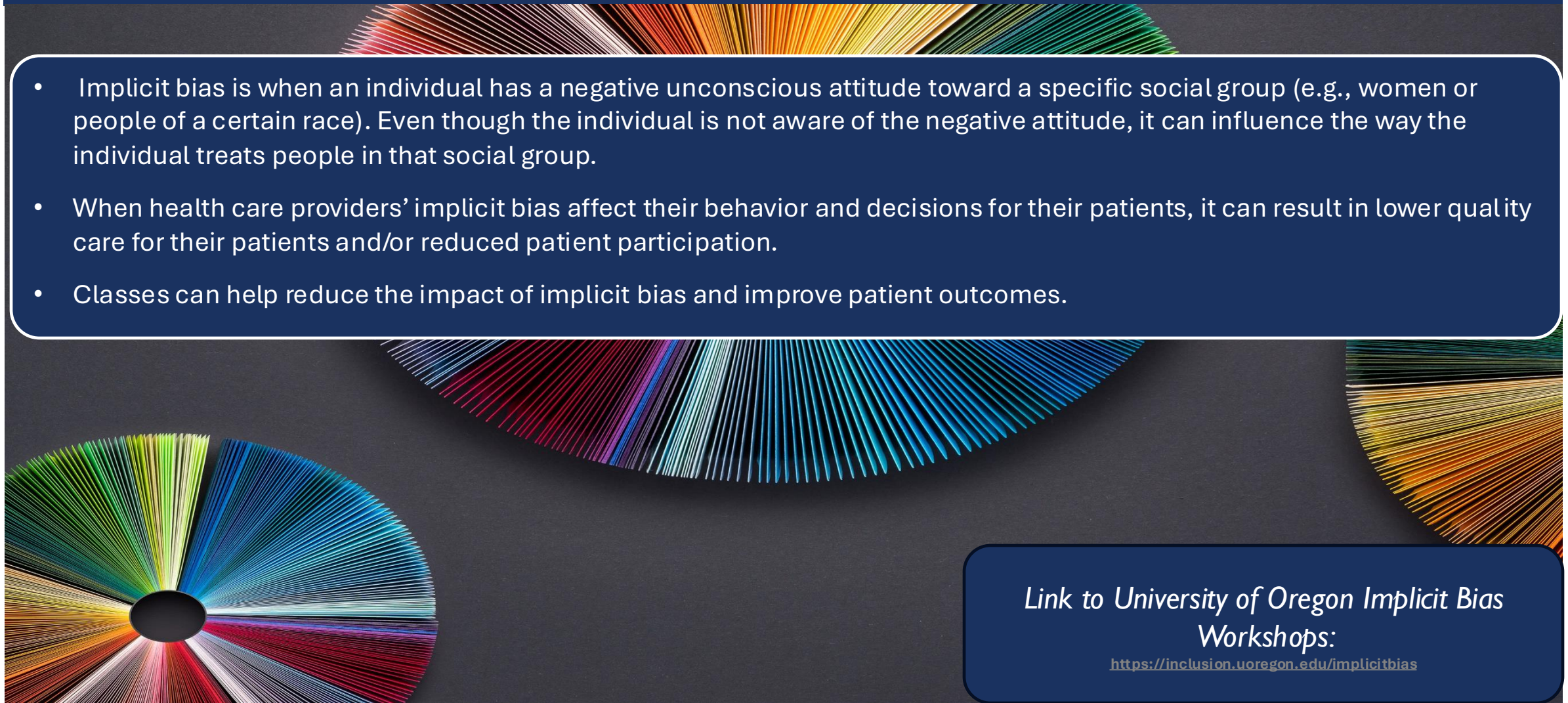
*Link to Board of Licensed Professional Counselors and Therapists Requirements:*
https://www.oregon.gov/oblpct/Pages/CCCE.aspx

*Link to OHA Cultural Competency Education:*
https://www.oregon.gov/omb/topics-of-interest/pages/health-care-interpreter-requirements.aspx

*Link to Board of Licensed Social Workers Requirements:*
https://www.oregon.gov/blsw/pages/continuingeducation.aspx

# IMPLICIT BIAS

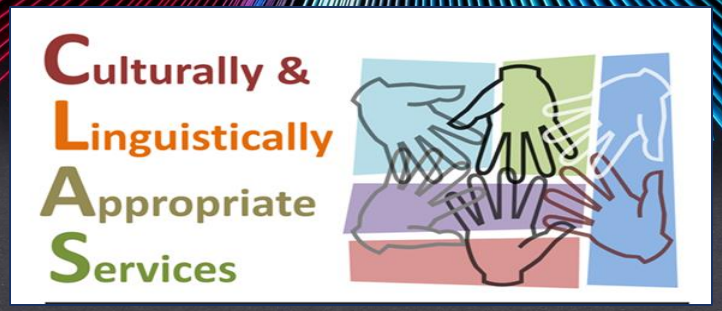
- Implicit bias is when an individual has a negative unconscious attitude toward a specific social group (e.g., women or people of a certain race). Even though the individual is not aware of the negative attitude, it can influence the way the individual treats people in that social group.
- When health 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.



*Link to University of Oregon Implicit Bias Workshops:*
https://inclusion.uoregon.edu/implicitbias

# 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 CMS Guide to CLAS:*
https://www.cms.gov/about-cms/agency-information/omh/downloads/clas-toolkit-12-7-16.pdf

*Link to National CLAS Standards:*
https://thinkculturalhealth.hhs.gov/clas

*Link to National Equity Project:*
https://www.nationalequityproject.org/frameworks/lens-of-systemic-oppression

# TRAUMA INFORMED CARE (TIC)

- The healthcare system can retraumatize individuals which might affect their willingness to participate and engage.
- UHA providers are expected to care for members using trauma-informed practices to improve patient safety. Providers must integrate trauma awareness, promote safety, support choice & empowerment, and provide strengths-based care.

**The Four Rs of Trauma-Informed Care**

| Realize | Recognize | Respond | Resist |
|---|---|---|---|
| • The widespread impact of trauma and understand there are many potential paths for recovery | • The signs and symptoms of trauma in clients, families, staff, and others involved with the system | • By fully integrating knowledge about trauma into policies, procedures, and practices; seek to actively resist re-traumatization | • Re-traumatization of clients as well as staff |

*Link to Principles of Trauma-informed Care:*
https://traumainformedoregon.org/resources/trauma-informed-care-principles/

*Link to Trauma Informed Oregon training:*
https://traumainformedoregon.org/trauma-informed-oregon-training-module-registration/

*Link to Trauma Informed Oregon video:*
https://vimeo.com/787823118

*Link to Trauma Informed definitions:*
https://traumainformedoregon.org/wp-content/uploads/2020/06/Key-Terms-Related-to-Realizing-the-Widespread-Impact-of-Trauma.pdf

# ADVERSE CHILDHOOD EXPERIENCES (ACES)

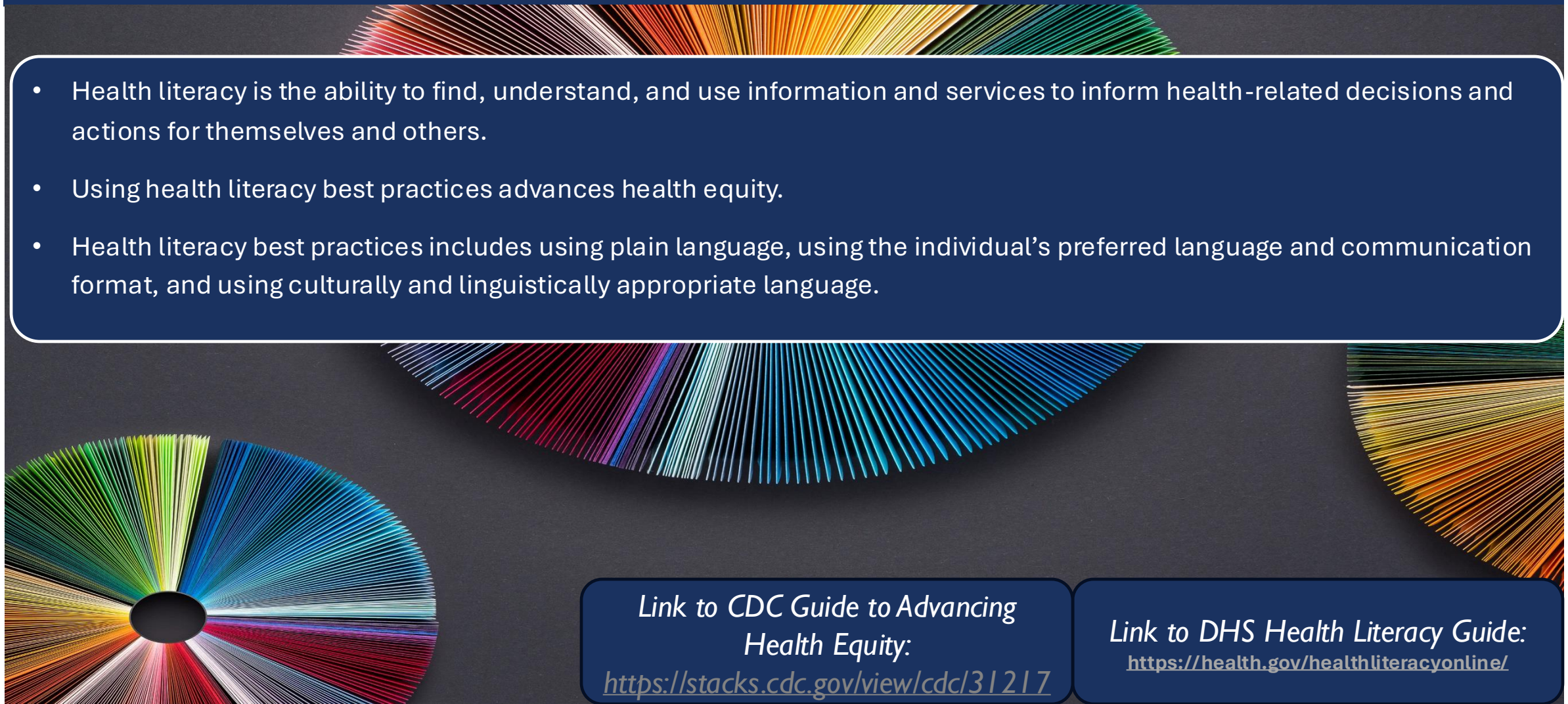
- ACE exposure is associated with increased risk for health problems across the lifespan.
- ACEs are common. About 64% of U.S. adults reported one or more ACE and 17.3% reported four or more.
- Preventing ACEs could potentially reduce many health conditions. Up to 1.9 million heart disease cases and 21 million depression cases potentially could have been avoided.
- Some people are at greater risk of experiencing ACEs. Studies have shown ACE experiences linked to the historical, social, and economic environments. ACEs were highest among females, non-Hispanic American Indian or Alaska Natives, and adults who are unemployed or unable to work.
- ACEs are costly. ACEs-related health consequences cost $748 billion annually in Bermuda, Canada, and the United States.

*Link to Research Article:*
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2816502

*Link to CDC Resource :*
https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf

*Link to Guidelines for Medical Interpreter Services:*
https://vetoviolence.cdc.gov/apps/aces-training/

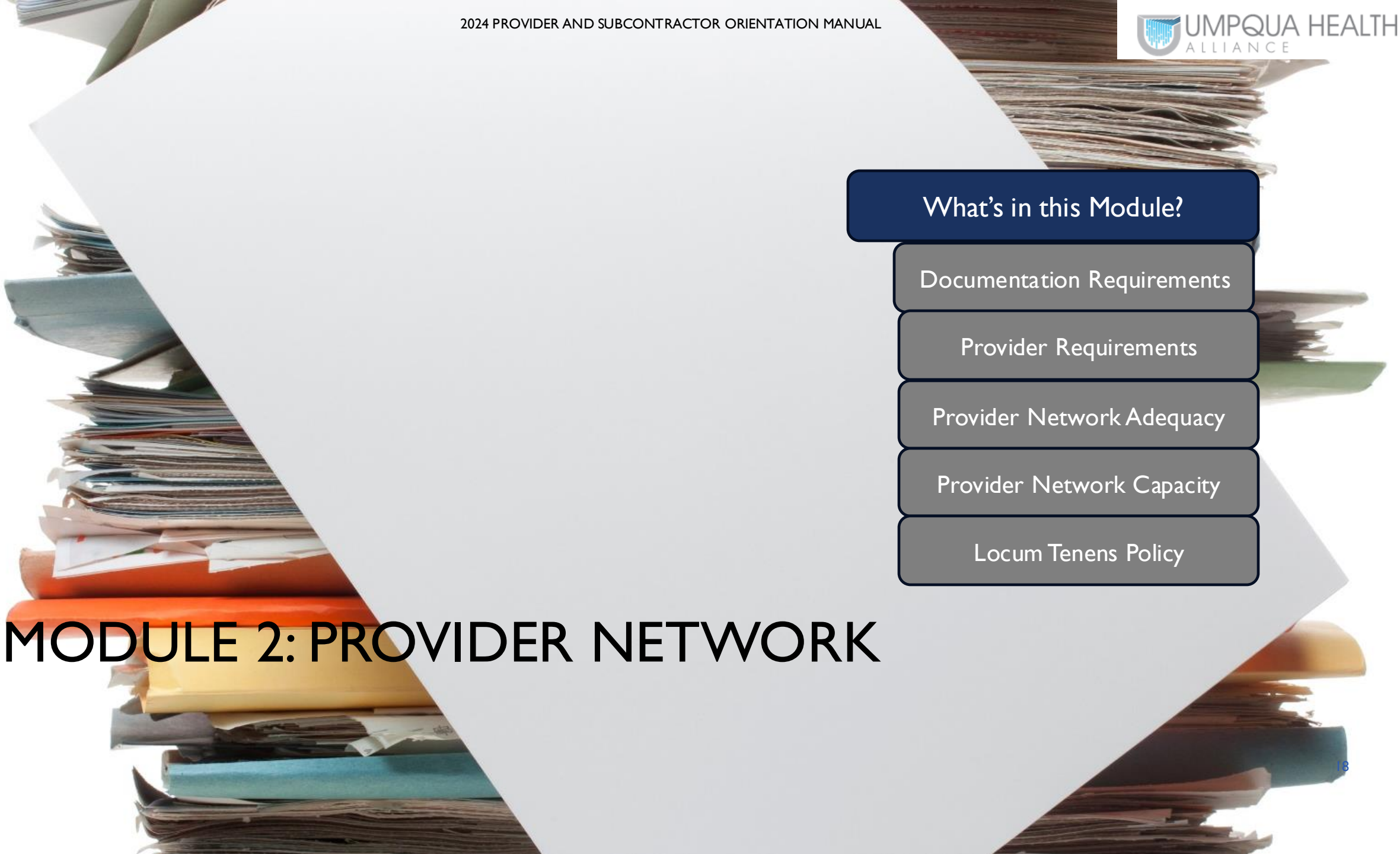
# HEALTH LITERACY



- 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:*
*https://stacks.cdc.gov/view/cdc/31217*

*Link to DHS Health Literacy Guide:*
**https://health.gov/healthliteracyonline/**



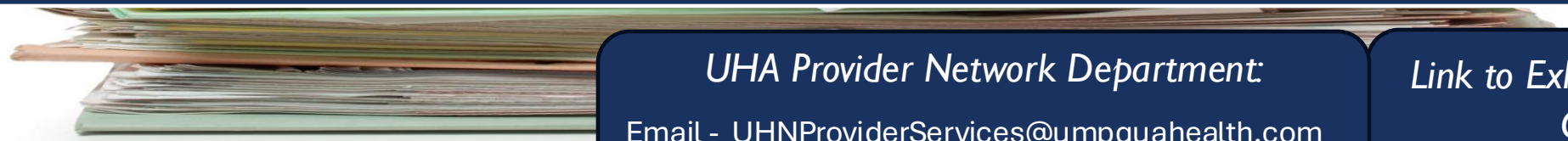
What's in this Module?

- Documentation Requirements
- Provider Requirements
- Provider Network Adequacy
- Provider Network Capacity
- Locum Tenens Policy

# MODULE 2: PROVIDER NETWORK

# DOCUMENTATION REQUIREMENTS

- Credentialing activities under UHA's CCO Contract (by UHA or subcontractors) are required to have written policies and procedures for: collecting evidence and screening credentials, reporting credential information, and recredentialing providers.
- UHA and its subcontractors (delegated credentialing activities) are required to maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank. Documentation must also include proof of professional liability Insurance, even when provider uses a program of self-insurance.
- Accurate and timely information about license or certification expiration and renewal dates in the DSN Provider Capacity Report are required to be made in accordance with Exhibit G of the CCO Contract.



*UHA Provider Network Department:*

Email - UHNProviderServices@umpquahealth.com

Phone - 458-803-4058

*Link to Exhibit G of the CCO Contract:*

*https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf*

# PROVIDER REQUIREMENTS

- UHA subcontractors may not refer members to providers without the valid license/certification required by applicable Law.
- UHA and its subcontractors will not employ or contract with providers excluded from participation in federal health care programs.
- UHA and its subcontractors will not accept claims for services provided to members after the date of the provider's exclusion, conviction, or termination from the network.
- If UHA or its subcontractors learn that a provider has been convicted of a crime related to violation of federal or state law under Medicare, Medicaid, or Title XIX, or that their license/certification has expired, UHA and its subcontractors will immediately notify OHA. Subcontractors can alternatively notify UHA who will then notify OHA.
- Prior to entering into a contract and credentialing a provider, UHA and its subcontractors must identify and confirm whether the provider is designated moderate or high-risk by CMS through verification of the Medicaid enrollment report with OHA. OHA will then conduct site visits and background checks of these providers.
- UHA and its subcontractors will require providers use registered National Provider Identifiers (NPIs) and taxonomy codes, which will be used to make the DSN Provider Capacity Report to OHA.

*Link to UHA Non-licensed Provider Qualifications and Competencies Policy:* https://www.umpquahealth.com/?wpdmdl=14066%27%3ECR20%3C/a%3E

*Link to UHA Traditional Health Worker requirements Policy:* https://www.umpquahealth.com/?wpdmdl=14065%27%3ECR19%3C/a%3E

*Link to 42 CFR § 1001.101:* https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001/subpart-B/section-1001.101

*Link to 42 CFR § 455.3(b):* https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/section-455.3

*Link to OHA Provider Enrollment files:* https://umpquahealth-my.sharepoint.com/personal/checkert_umpquahealth_com/Documents/Documents/(https://www.oregon.gov/oha/HSD/OHP/Pages/Plan-%20Tools.aspx

*Link to CMS Provider Types and Risk Categories:* https://www.oregon.gov/oha/HSD/OHP/Tools/CMS-Provider-Risk-Categories.pdf

*Link to UHA Practitioners Within Credentialing Scope Policy:* https://www.umpquahealth.com/?wpdmdl=14059%27%3ECR1%3C/a%3E

*Link to UHA Screening of Providers Policy:* https://www.umpquahealth.com/?wpdmdl=14060%27%3ECR3%3C/a%3E

*Link to UHA Credentialing and Recredentialing Process Policy:* https://www.umpquahealth.com/?wpdmdl=14061%27

# PROVIDER NETWORK ADEQUACY

- UHA assesses its network adequacy at least quarterly based on:
  - Provider availability requirements
  - Time and distance standards
  - Member-to-Primary Care Provider (PCP) ratio
  - Grievance analysis
  - Special requests and accommodations
  - Utilization trends
  - Requests for out-of-network services
  - Requests for second opinions
  - Community Needs Assessment
  - Consumer Assessment of Health Care Providers and System access to care and satisfaction survey results
- For those services to which UHA has delegated to a subcontractor, the subcontractor must comply with the requirements outlined in the CCO Contract and OAR 410-141-3515.

Link to CCO Contract: https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf

Link to OAR 410-141-3515: https://oregon.public.law/rules/oar_410-141-3515

Link to UHA Network Adequacy Policy: https://www.umpquahealth.com/?wpdmdl=14050%27%3EPN7%3Cla%3E

Link to 42 CFR §438.206: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.206

Link to UHA Monitoring Network Access: https://www.umpquahealth.com/?wpdmdl=14052%27%3EPN9%3Cla%3E

Link to UHA Provider Selection Policy: https://www.umpquahealth.com/?wpdmdl=14053%27%3EPN11%3Cla%3E

# PROVIDER NETWORK CAPACITY

UHA will monitor its provider network capacity based on the:

- Anticipated Medicaid enrollment and anticipated enrollment of full benefit dual eligible individuals;
- Appropriate range of preventative and specialty services for population enrolled and expected to be enrolled;
- Expected utilization of services, taking into consideration members' physical, oral, and behavioral health care needs;
- Number and types (in terms of training, experience, and specialization) of providers required to provide services under its CCO Contract;
- Sufficiency of Indian Health Care Providers, according to 42 CFR § 438.14(b)(1) and CCO Contract;
- Geographical location of participating providers and members considering distance, travel time, transportation ordinarily used by members and whether the location provides physical access for members with disabilities;
- Data collected from UHA's grievance and appeal system;
- Data collected from UHA's monitoring of wait time to appointment;
- Deficiencies in network adequacy or access to services identified through the course of self-audit, OHA monitoring, or reviews conducted by OHA's External Quality Review Organization or by any other State or Federal agency;
- Number of providers who are not accepting new members; and
- Number of members assigned to patient-centered primary care homes.

| Link to Provider Manual: | Link to CCO Contract: | Link to 42 CFR § 438.14(b)(1): | Link to ORS 414.609: | Link to UHA Monitoring Network Availability Policy: |
|---|---|---|---|---|
| https://www.umpquahealth.com/provider-trainings/ | https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf | https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.14 | https://oregon.public.law/statutes/ors_414.609 | https://www.umpquahealth.com/?wpdmdl=14051%27%3EPN8%3Cla%3E |

# LOCUM TENENS POLICY

- Providers must notify UHN at UHNProviderServices@UmpquaHealth.com about the locum tenens.
  - If UHN does not receive the required information or provider does not meet requirements of OAR 410-120-1260 and OAR 847-008-0020, payments will be suspended, and services will not be reimbursed.
- Exclusion reports will be run monthly on the locum tenens provider.
- Services must be billed with a modifier Q5 (reciprocal billing arrangement) or Q6 (services provided by locum tenens).
- In accordance with 1842(b)(6)(D)(iii) of the Social Security Act, CMS general billing requirements, and Medicare, Medicaid, and SCHIP Extension Act of 2007, locum tenens has a 60-day limitation per 12-month period except when provider is called to Active Duty.
- Initial credentialing process will be required for a locum tenens taking over for a deceased physician or one serving longer than 60 days, such as for replacing a provider called to Active Duty.

Link to SCHIP Extension Act of 2007:
https://www.ssa.gov/OP_Home/comp2/F110-173.html

Link to UHA Locum Tenens Policy:
https://www.umpquahealth.com/?wpdmdl=14063%27%3ECR13%3C/a%3E

Link to OAR 847-008-0020:
https://oregon.public.law/rules/oar_847-008-0020

Link to OAR 410-120-1260:
https://oregon.public.law/rules/oar_410-120-1260

UMPQUA HEALTH ALLIANCE

# MODULE 3: MEMBER ENGAGEMENT

What's in this Module?

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

# 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<br>•**Toll free:** 866-672-1551<br>•**TTY:** 541-440-6304<br>•**Hours:** Monday – Friday, 8AM – 5PM | • 541-677-5881 | UHAGrievance@umpquahealth.com | •Grievance & Appeals 3031 NE Stephens St. Roseburg, OR 97470<br>•UHA 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

*Link to Member Handbook:* [https://www.umpquahealth.com/?wpdmdl=12081%27%3EMember%20Handbook%3C/a%3E

*Link to Provider Handbook:* https://www.umpquahealth.com/download/provider-handbook/

*Link to OAR 410-141-3515* https://oregon.public.law/rules/oar_410-141-3515

*Link to OAR 410-141-3875 to OAR 410-141-3915:* https://oregon.public.law/rules/oar_chapter_410_division_141

# 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*:*
https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=305868

*Link to CCO Contract:*
https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf

*Link to UHA Grievances, Appeals, and Hearing Policy:*
https://www.umpquahealth.com/?wpdmdl=14100%27%3ECE01%3Cla%3E

*Link to 42 CFR §438.400 to 438.424:*
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F?toc=1

# 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 (NOABD) | • Oral acknowledgement. Expedited requests are within 1 BD. | • Written acknowledgement. Expedited requests are within 1 BD. | • Resolution. Expedited requests are within 72 hours. | • Resolution extension |
| 60 days | 2 business days | 5 days | 16 days | 14 extra days |

# 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.

# CARE COORDINATION

*Link to UHA Substance Use Disorder Policy:* https://www.umpquahealth.com/?wpdmdl=14095%27%3ECE19%3C/a%3E

*Link to OAR 410-141-3860:* *https://oregon.public.law/rules/oar_410-141-3860*

*Link to UHA Care Coordination Policy:* https://acrobat.adobe.com/id/urn:aaid:sc:va6c2:7f38bc60-3111-47ea-af06-467a5c64240c

**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**

# 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

# 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 UHA Provider Newsletter:* https://signup.e2ma.net/signup/1846531/1716984/

*Link to OAR 410-141-3565:* https://oregon.public.law/rules/oar_410-141-3565

*Link to OAR 410-141-3515:* https://oregon.public.law/rules/oar_410-141-3515

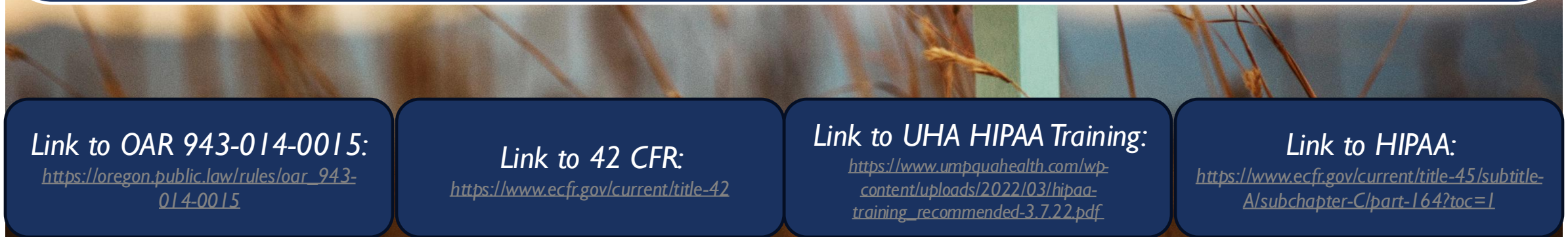
# ADA AND UNIVERSAL ACCESS

- 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.

*Link to Removing Barriers to HealthCare Article:*
https://fpg.unc.edu/publications/removing-barriers-health-care-guide-health-professionals

# PATIENT CONFIDENTIALITY

- 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.



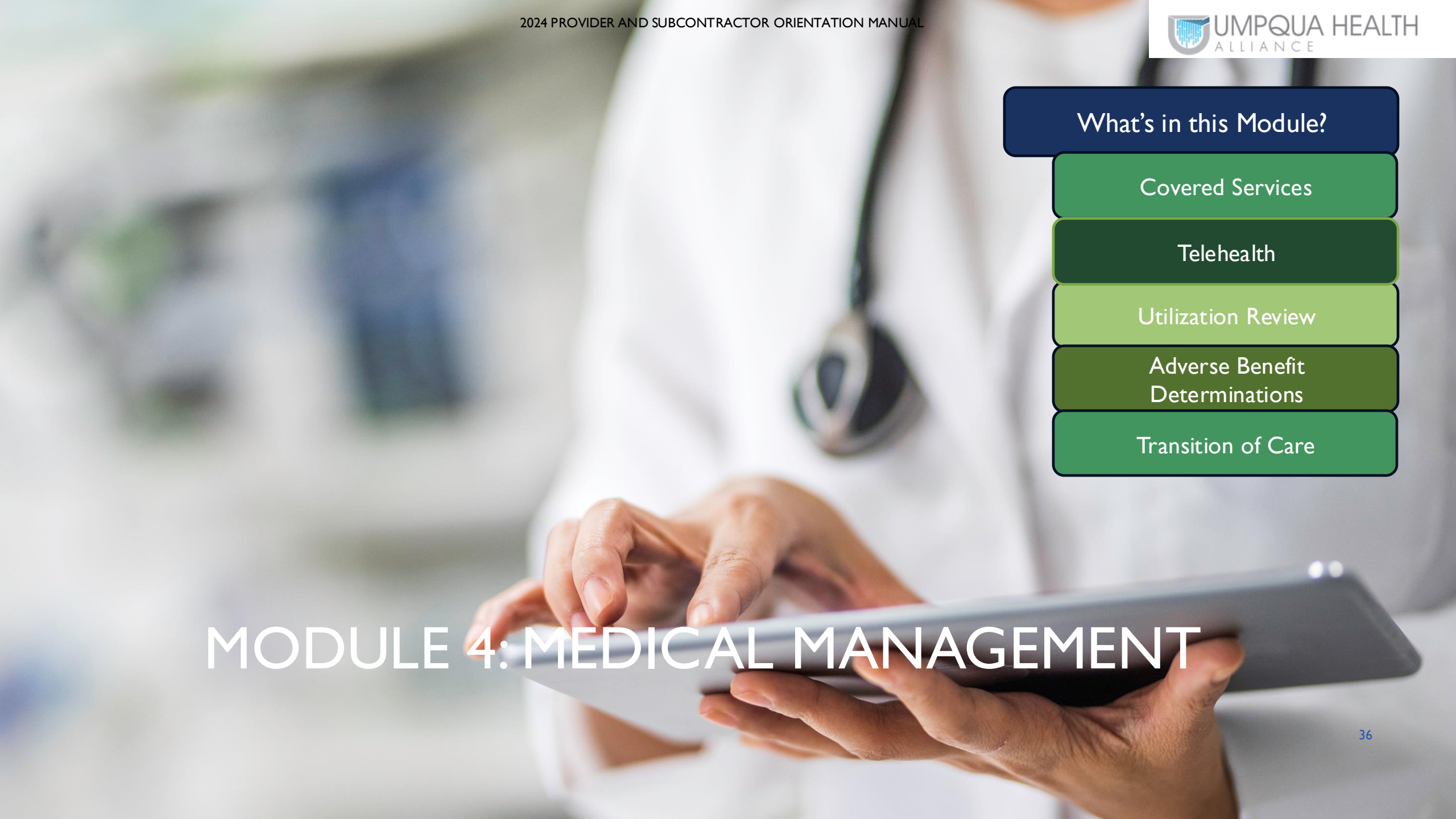
*Link to OAR 943-014-0015:*
https://oregon.public.law/rules/oar_943-014-0015

*Link to 42 CFR:*
https://www.ecfr.gov/current/title-42

*Link to UHA HIPAA Training:*
https://www.umpquahealth.com/wp-content/uploads/2022/03/hipaa-training_recommended-3.7.22.pdf

*Link to HIPAA:*
https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164?toc=1

UMPQUA HEALTH ALLIANCE



## What's in this Module?

- Covered Services
- Telehealth
- Utilization Review
- Adverse Benefit Determinations
- Transition of Care

# MODULE 4: MEDICAL MANAGEMENT

# 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 Payment and Authorization of Hospital Admissions Policy:*
https://www.umpquahealth.com/?wpdmdl=14097%27%3ECE22%3Cla%3E

*Link to UHA Covered Services Policy:*
https://www.umpquahealth.com/?wpdmdl=14104%27%3ECE11%3Cla%3E

# TELEHEALTH

*Link to UHA Telehealth Telemedicine Policy:* https://www.umpquahealth.com/?wpdmdl=14054%27%3EPN13%3C/a%3E

*Link to OAR 410-120-1990:* https://oregon.public.law/rules/oar_410-120-1990

- Telehealth services may be transmitted via landlines and wireless communications, including the internet and telephone networks.
- Services can be synchronous (using audio and video, video only or audio-only) or asynchronous (using audio and video, audio, or text-based media) and may include transmission of data from remote monitoring devices.
- Providers should consider the appropriateness of telehealth, including whether patients have the necessary devices, access to privacy, and whether there is a cultural or other reason why telehealth services may not be appropriate.
- Providers can't force members to choose telehealth over in-person services, except when OHA issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.
- Provider must document member's agreement of consent to receive services.
- UHA will only pay for telehealth services that are medically and clinically appropriate for covered conditions within the Health Evidence Review Commission's (HERC) prioritized list and in compliance with relevant guideline notes.
- UHA shall provide reimbursement for telemedicine or telehealth services at the same reimbursement rate as if it were provided in person.

# TELEHEALTH

- Telehealth services must comply with HIPAA and with OHA's Privacy and Confidentiality Rules, including utilizing compliant technology.
- The member must be located within the state where the provider is certified/licensed and may be in the community or in a health care setting.
- Provider and interpreter must be located where patient privacy and confidentiality can be ensured.
- Telehealth services must be within the provider's respective certification or licensing board's scope of practice.
- Providers must ensure that telehealth services meets the same standards as for in-person services, including access to services for LEP and deaf/hard of hearing patients, access to culturally and linguistically appropriate care, and the use of a trauma informed approach.

*Link to OAR 410-120-1380:*
https://oregon.public.law/rules/oar_410-120-1380

*Link to OAR 410-120-1360:*
https://oregon.public.law/rules/oar_410-120-1360

*Link to HIPAA:*
https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164?toc=1

# TELEHEALTH

Teledentistry

- All rules, criteria, and limits apply to teledentistry services in the same manner as other services.
- Per ORS 679.543, payment for dental services will not differentiate between services performed using teledentistry, real time, or store-and-forward and services performed in-person.
- Originating site may bill a CDT code only if a separately identifiable service is performed within the scope of practice of the practitioner providing the service. The service shall meet all criteria of the CDT code billed.
- A patient receiving services through teledentistry shall be notified of the right to receive interactive communication with the distant dentist and shall receive an interactive communication with the distant dentist upon request.
- The patient's chart documentation shall reflect notification of the right to interactive communication with the distant site dentist.
- A patient may request to have real time communication with the distant dentist at the time of the visit or within 30 days of the original visit.

*Link to UHA Teledentistry Policy:* https://www.umpquahealth.com/?wpdmdl=14055%27%3EPN14%3Cla%3E

*Link to ORS 679.543:* https://oregon.public.law/statutes/ors_679.543

*Link to OAR 410-120-1990:* https://oregon.public.law/rules/oar_410-120-1990

*Link to OAR 410-120-1200:* https://oregon.public.law/rules/oar_410-120-1200

# 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 1 or email priorauthorizations@umpquahealth.com. Peer-to-peer can occur at the same time a member is in the process of appealing a denial.

*Link to UHA Prior Authorization Policy:*
https://umpquahealth.navexone.com/content/dotNet/documents/?docid=174&app=pt&source=browse

*Link to UHA Utilization Review Policy:*
https://umpquahealth.navexone.com/content/dotNet/documents/?docid=174&app=pt&source=browse

# UTILIZATION REVIEW

**REVIEW CRITERIA**

PRIOR AUTHORIZATION REQUESTS THAT REQUIRE REVIEW ARE ASSESSED FOR MEDICAL APPROPRIATENESS AND NECESSITY BY USING THE FOLLOWING RESOURCES.

**Prioritized List of Health Services (PLHS)**

- The Oregon Health Evidence Review Commission (HERC) ranks health care condition and treatment pairs in order of clinical effectiveness and cost-effectiveness. https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

**Guideline Notes**

- Using the Prioritized List for the line of coverage, based upon ICD-10, CPT, and HCPCS codes, UHA will then find the associated Guideline Note for treatment. These guidelines can be found at https://www.oregon.gov/oha/HSD/OHP/pages/policies.aspx.

**InterQual®**

- InterQual® is an evidence-based clinical decision support tool used to make clinically appropriate medical utilization decisions.. Documentation of the InterQual® criteria is included in each PA used to make a determination in CIM, which can be accessed by CIM users.

**Oregon Administrative Rules (OAR)**

- https://secure.sos.state.or.us/oard/ruleSearch.action

**Up-to-Date ® Wolters Kluwer**

- UpToDate is an evidence-based clinical decision support resource at the point of care.

**Clinical Practice Guidelines**

- Umpqua Health Alliance's Clinical Practice Guidelines are adopted by UHA's Clinical Advisory Panel. They can be found on the UHA website at https://www.umpquahealth.com/clinical-practice-guidelines/.

**American Society of Addiction Medicine (ASAM)**

- The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

**Functional Rating Index© Institute of Evidence-**

**AllMed**

- Contracted Independent Review Organization UHA uses for evaluation of high cost DME or for any Expert Specialty review.

**CMS Inpatient Hospitalization List**

**Medicare Local Coverage Determination (LCD)**

# UTILIZATION REVIEW

REVIEW TYPES

**Pre-service review**

- These are services that require a prior authorization review before the service is rendered. These include all elective procedures, hospitalization, outpatient services, out-of-network referrals and durable medical equipment as indicated on UHA's PA Grid.

**Concurrent review**

- These requests are an extension of ongoing treatment or care. These are to be requested after the initial approval of a pre-service review and are required for all inpatient and/or residential care.

**Post-service review**

- These requests occur after the date of service. Any requests for authorization after 30 days from the date of service (90 days for Behavioral Health services) requires documentation from the provider that indicates why authorization could not be obtained within 30 days of the date of service. Post-service or retrospective reviews are discouraged and will need to be sent for provider appeals for coverage past these timelines.

**Amendments**

- These requests are to make a change after the final approval of an authorization. This includes changes/edits/additions of diagnosis codes, CPT/HCPC codes, date changes, provider changes, quantity changes. A request for additional visits will be considered a new request.

# UTILIZATION REVIEW

## 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, and prior authorizations:*
https://cim1.phtech.com/cim/login

# UTILIZATION REVIEW

PRIOR AUTHORIZATION TIMELINES

## PRIOR AUTHORIZATION TIMELINES

| Authorization Type | Timeline | Urgency |
|---|---|---|
| Standard requests | 14 days | Standard |
| Expedite requests<br>- 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 our team at priorauthorizations@umpquahealth.com. You can also reach us by phone at 541-229-4842.



UMPQUA HEALTH ALLIANCE

# ADVERSE BENEFIT DETERMINATION

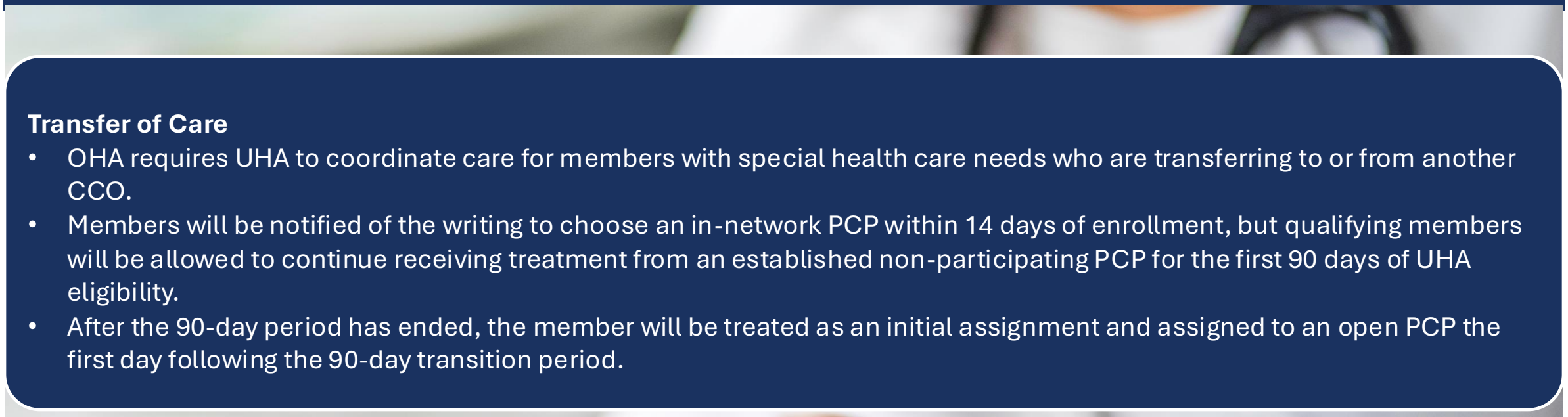
- Adverse benefit determinations are denials, reductions, terminations or failures to provide or pay, in whole or in part, for a benefit.
- Before denying any member treatment for a condition that is below the funding line on the Prioritized List of Health Services, UHA shall determine whether the member 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 for 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 an amount, duration, or scope less than what was requested.
  - It must be written in language that is easily understood.
  - It will include information about how to appeal the decision.

Link to UHA Adverse Benefit Determination Policy:
https://www.umpquahealth.com/?wpdmdl=14096%27%3ECE21%3C/a%3E

Link to 42 CFR §438.210:
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.210

*Link to OAR 410-141-3820:*
https://oregon.public.law/rules/oar_410-141-3820

# TRANSFER OF CARE TO/FROM ANOTHER CCO



**Transfer of Care**

- OHA requires UHA to coordinate care for members with special health care needs who are transferring to or from another CCO.
- Members will be notified of the writing to choose an in-network PCP within 14 days of enrollment, but qualifying members will be allowed to continue receiving treatment from an established non-participating PCP for the first 90 days of UHA eligibility.
- After the 90-day period has ended, the member will be treated as an initial assignment and assigned to an open PCP the first day following the 90-day transition period.

Link to UHA Transition of Care Policy:
https://www.umpquahealth.com/?wpdmdl=14098%27%3ECE28%3Ca%3E

UMPQUA HEALTH ALLIANCE

## What's in this Module?

- Transfer of Care to/from Another CCO
- PCP Assignment and Reassignments
- Nondiscrimination of Members
- Member Rights
- Member Responsibilities
- Request for Interpreter or Alternative Format

# MODULE 5: CUSTOMER CARE

# 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.

Link to UHA Assignment and Reassignment Policy:
https://www.umpquahealth.com/download/ms1/?wpdmdl=14068&refresh=672bd456835 1a1730925654

# NONDISCRIMINATION OF MEMBERS

- UHA and its oviders 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.
- 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
    Website and Complaint Form: https://www.umpquahealth.com/appeals-and-grievances/
  - U.S. Department of Health and Human Services Office for Civil Rights (OCR).
    1. Oregon Health Authority (OHA) Civil Rights
    Phone: (844) 882-7889, 711 TTY , Email: OHA.PublicCivilRights@state.or.us, Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750, Portland, OR 97204, Web: www.oregon.gov/OHA/OEI |
    2. Bureau of Labor and Industries Civil Rights Division
    Phone: (971) 673-0764, Email: crdemail@boli.state.or.us, Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045 Portland, OR 97232
    3. U.S. Department of Health and Human Services Office for Civil Rights (OCR), Web: https://ocrportal.hhs.gov/ocr/smartscree n/main.jsf
    Phone: (800) 368-1019, (800) 537-7697 (TDD), Email: OCRComplaint@hhs.gov, Mail: Office for Civil Rights, 200 Independence Ave. SW, Room 509F, https://www.umpquahealth.com/?wpdmdl=14074%27%3EMS2%3C/a%3E HHH Bldg. Washington, DC 20201

Link to UHA Nondiscrimination of Members Policy:
https://www.umpquahealth.com/download/ms1/?wpdmdl=14068&refresh=672bd456835la1730925654

# MEMBER RIGHTS

**Notification of Member Rights and Course of Action for Violations**

- Members are informed in writing of their rights and responsibilities through the Member Handbook, which is provided to members within 14 days upon enrollment/re-enrollment and is available upon request.
- Internal and external personnel are required to comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure they observe and protect those rights. Failure to do so will result in corrective actions in accordance with policy CO19 – Disciplinary Process for Compliance Infractions, up to and including termination of employment or contract.
- Members may contact UHM's Customer Care Department if they feel their rights were violated and a grievance will be filed.

Link to 42 CFR §438.100:
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C/section-438.100

Link to OAR 410-141-3590:
https://oregon.public.law/rules/oar_410-141-3590

Link to UHA Member Rights Policy:
https://www.umpquahealth.com/?wpdmdl=14071%27%3EMS3%3C/a%3E

Link to UHA CCO Contract Exhibit B Part 3:
https://www.oregon.gov/oha/HSD/OHP/CCO/2025-Medicaid-Contract-Template.pdf

# MEMBER RIGHTS

**List of Member Rights**

- To be treated with dignity and respect with consideration for member's privacy.
- To be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs.
- To choose a health professional, including Primary Care Providers (PCP), or service site from available participating providers, and to change those choices as permitted by UHA's administrative policies. For a member in a service area serviced by only one Prepaid Health Plan (PHP), any limitation UHA imposes on his or her freedom to change between PCPs or to obtain services from non-participating providers if the service or type of provider is not available with the UHA's provider network may be no more restrictive than the limitation on disenrollment under CCO contract Exhibit B, Part 3, section 9.
- To refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;
- To have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines.
- To be actively involved in the development of their treatment plan.
- To receive information about their condition and covered and non-covered services to allow an informed decision about proposed treatments, including alternative treatments, that is presented in a manner appropriate to the member's condition, preferred language, and ability to understand, including provision of auxiliary aids and services to ensure disability access to health information as required by Section 1557 of the PPACA;
- To participate in decisions regarding their healthcare, including consenting to treatment or the right to refuse services (i.e., medical, surgical, substance use disorders, and/or mental health treatment) and be told the consequences of that decision, except for court ordered services.
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency.
- Have written materials explained in a manner that is understandable to the member or potential member that explains the requirements and benefits of UHA's plan, the coordinated care approach being used in the community and how to navigate the coordinated health care system.
- To receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.

# MEMBER RIGHTS

- To receive oversight, care coordination and transition and planning management from UHA to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care.
- To receive necessary and reasonable services to diagnose the presenting condition.
- To receive integrated person-centered care and services designed to provide choice, independence, and dignity and that meet generally accepted standards of practice and are medically appropriate.
- To have a consistent and stable relationship with a care team that is responsible for comprehensive care management.
- To receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, personal health navigators and advocates, who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
- To obtain covered preventive services.
- To have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization.
- To receive a referral to specialty providers for medically appropriate covered coordinated care services, in the manner provided in the CCO's referral policy.
- The right to be furnished with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services for female enrollees. This is in addition to the Member's designated PCP if the designated PCP is not a women's health Specialist.
- To get needed covered services. If UHA's provider network is unable to provide these services, UHA will, in a timely manner, cover these services to an out of network provider until our network can provide them.
- Be furnished with health care services in accordance with 42 CFR 438.206 through 438.210 and as outlined in internal policies CE11 – Covered Services, CE12 – Prior Authorizations, and PN7 – Provider Network Adequacy, Availability, and Access.
- To have a clinical record maintained which documents conditions, services received, and referrals made.

# MEMBER RIGHTS

- To have access to one's own clinical record, unless restricted by ORS 179.505 or other applicable law and to request that the records be amended or corrected as specified in 45 CFR Part 164.524 and 164.526;
- To transfer of a copy of the clinical record to another provider.
- To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 -- Patient Self-Determination Act.
- To receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations.
- To be able to file a complaint (grievance) or appeal, orally or in writing, or have a provider or an authorized representative with written consent file on the member's behalf either to UHA or to the State and receive a response from UHA.
- To request a contested case hearing.
- To receive Certified or Qualified Health Care Interpreter Services available free of charge for all members and potential members for all covered services, including but not limited to dental, vision, specialist, and NEMT services. This applies to all non-English languages, not just those that Oregon Health Authority (OHA) identifies as prevalent.
    - UHA shall notify its members and potential members that oral interpretation is also available free of charge for any language and that written information is available in prevalent non-English languages in service area(s) as specified in 42 CFR § 438.10(d)(4) for all covered services. UHA shall notify its members how to access oral interpretation and written translation services.
    - UHA will make its staff and provider network for all covered services aware of the URL for Oha's health care interpreter registry (https://hciregistry.dhsoha.state.or.us)
- To receive a notice of an appointment cancellation in a timely manner.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations specified in Federal regulations on the use of restraints and seclusion.

# MEMBER RIGHTS

- To be made aware that a second opinion is available from a qualified health care professional within the provider network, or that UHA will arrange for members to obtain a qualified health care professional from outside the provider network, at no cost to the members.
- To be made aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that a member has a right to report a complaint of discrimination by contacting UHA, OHA, the Bureau of Labor, and Industries (BOLI) or the Office of Civil Rights (OCR).
- To be notified of UHA's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, disability, or health status in accordance with all applicable laws including Title VI of the Civil Rights Act, ORS Chapter 659A and OAR 943-005-0060.
- To have equal access for both males and females under 18 years of age to appropriate facilities, services, and treatment under this Contract, consistent with OHA obligations under ORS 417.270.
- To be furnished with the information specified in 42 CFR § 438.10(f)(2)-(3), and 42 CFR § 438.10(g), if applicable, as specified in the CFR within 30 days after the UHA received notice of the member's enrollment from OHA or for members who are Fully Dual Eligible, within the time period required by Medicare. UHA shall notify all members of their right to request and obtain the information described in this section at least once a year.
- Consistent with the scope of UHA's contracted services, members have the right to be furnished with health care services in accordance with 42 CFR § 438.206 through 438.210.
- UHA shall ensure, and cause its participating providers to ensure, that each member is free to exercise their rights, and that the exercise of those rights does not adversely affect the way the UHA, its staff, subcontractors, participating providers, or OHA, treat the member. UHA shall not discriminate in any way against members when those members exercise their rights under the OHP.
- Ensure that any cost sharing authorized under the CCO contract for members is in accordance with 42 CFR § 447.50 through 42 CFR § 447.90 and the applicable Oregon Administrative Rules.
- To be notified of their responsibility for paying a co-payment for some services, as specified in OAR 410-120-1280; and

# MEMBER RESPONSIBILITIES

- Choose or help with assignment to a PCP or service site.
- Treat UHA, provider, and clinic staff members with respect.
- Be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if expected to be late.
- Seek periodic health exams and preventive services from the PCP or clinic.
- Use the PCP or clinic for diagnostic and other care except in an emergency.
- Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed.
- Use urgent and emergency services appropriately and notify the member's PCP or clinic within 72 hours of using emergency services in the manner provided in UHA's referral policy.
- Give accurate information for inclusion in the clinical record
- Help the provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information.
- Ask questions about conditions, treatments, and other issues related to care that is not understood.
- Use information provided by UHA providers or care teams to make informed decisions about treatment before it is given.
- Help in the creation of a treatment plan with the provider.
- Follow prescribed agreed upon treatment plans and actively engage in their health care.
- Tell the provider that the member's health care is covered under UHA before services are received and, if requested, show the provider the Medical Care Identification card provided by UHA.
- Tell the Department or Authority worker of a change of address or phone number.
- Tell the Department or Authority worker if the member becomes pregnant and notify the worker of the birth of the member's child.
- Tell the Department or Authority worker if any family members move in or out of the household.
- Tell the Department, Authority or UHA worker if there is any other insurance available.
- Pay for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280.
- Pay the monthly OHP premium on time if so required.
- Assist UHA in pursuing any third-party resources available and reimburse UHA the number of benefits it paid for an injury from any recovery received from that injury; and
- Bring issues or complaints or grievances to the attention of UHA.

UMPQUA HEALTH ALLIANCE

## What's in this Module?

- Payer of Last Resort
- Third Party Liability Communication
- Claim Adjustment Refund Requests

# MODULE 6: RECOVERY

# PAYER OF LAST RESORT

- Current federal regulations require Medicaid to pay for health care only after the Member's other health resources have been exhausted. In other words, Medicaid is viewed as the payer of last resort, except when members have Tribal coverage. The requirement that third parties pay first is called Medicaid "third party liability" (TPL).
- In guidelines issued by the CMS, TPLs are defined as individuals, entities, insurers, or programs that may be liable to pay all or part of the expenditures for medical assistance provided under a state Medicaid plan.
    - Examples of third parties include: commercial insurers, individual plans, for profit or non-profit pre-paid plans, Medicare, Tricare, Champva, automobile insurance, state worker's compensation, and other Federal programs.
- If the member has any liability for cost-sharing under the other primary insurance, UHA shall pay the amount of the member's cost-sharing to the other primary insurance.

# THIRD PARTY LIABILITY COMMUNICATION

- Providers must contact UHA's TPR Department at TPR@umpquahealth.com if any of the following events occur:
  - Member has other insurance which is not noted by UHA
  - Member is pursuing a settlement for an injury or illness
  - Member is in police custody at the time treatment is rendered
  - Member mentions employer's name, Workman's Comp injury, and/or motor vehicle accident
    - Provider will need to complete UHA's Member Accident Form and the Patient Coordination of Benefits Intake Form and submit them to the UHA TPR Department.
- Providers are required to report within 30 days of becoming aware of member's alternative coverage to both UHA and OHA.

Link to UHA Third Party Liability Policy:
https://www.umpquahealth.com/?wpdmdl=14067%27%3EF18%3Cla%3E

Link to Provider Handbook:
https://www.umpquahealth.com/provider-trainings/

# CLAIM ADJUSTMENT REFUND REQUESTS

- Claim adjustment may sometimes be required due to the discovery of third party liability or due to correcting an error that was made in processing the claim.
  - When an overpayment is identified, UHA will issue “refund requests” to Providers.
  - Providers should forward the requested reimbursement within thirty (30) days of receiving the request.
  - If reimbursement is not received within thirty (30) days of the request, UHA may recover the owed amount by deducting it from the Providers’ future claim payments.

# COMPLIANCE & FWA PREVENTION PROGRAM

TRAINING REQUIREMENT

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

Review UHA Policies:

- Compliance Program Manual
- Fraud, Waste, and Abuse Prevention Handbook
- UHA Code of Conduct

Also see:

- Provider Handbook Section 10




UMPQUA HEALTH ALLIANCE

# 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 results in an unnecessary cost to the Medicaid program (any healthcare benefit program).

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

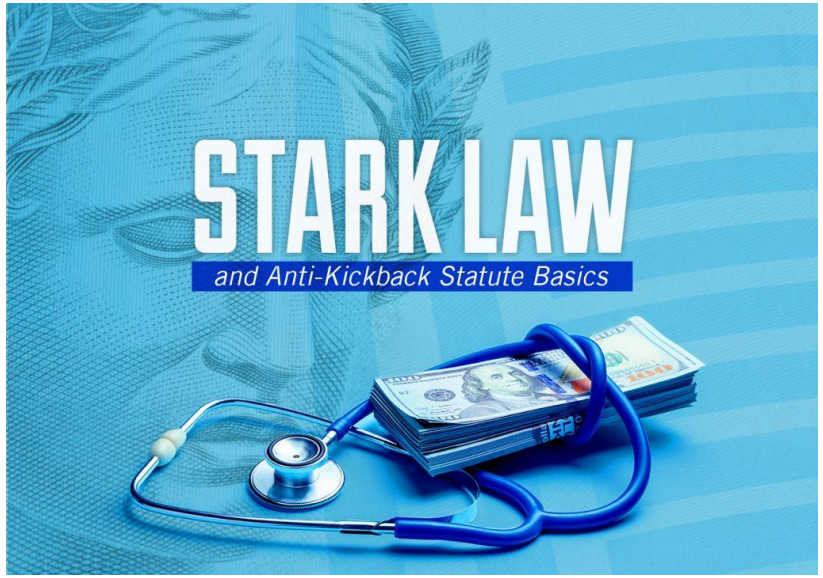
# FRAUD, WASTE, AND ABUSE (FWA)

**As a Medicaid provider, there are requirements of you in your role 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:

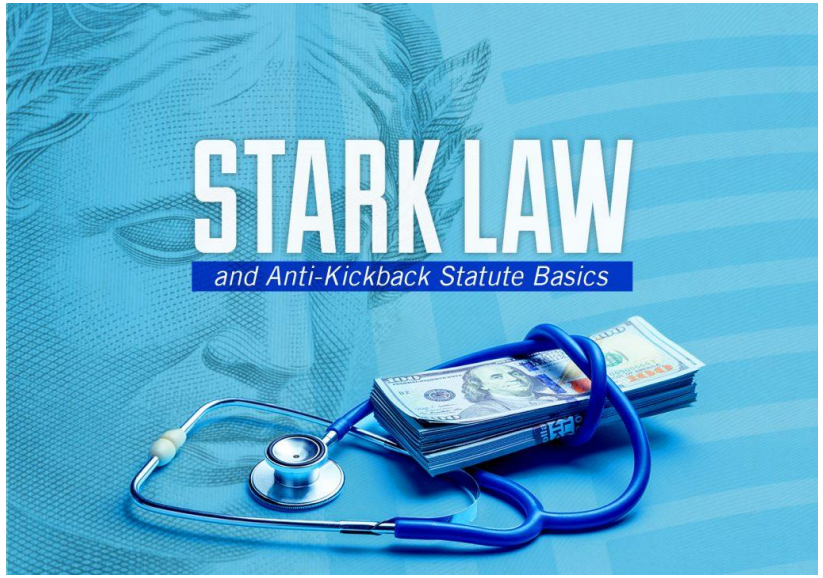



- **The Anti-Kickback Statute (AKS)** makes it illegal to solicit any kind of compensation in exchange for patient referrals for services covered by federal healthcare.
  - This means anything of value, such as free or discounted rent, hotel stays, expensive meals, etc. are illegal to exchange for patient 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.

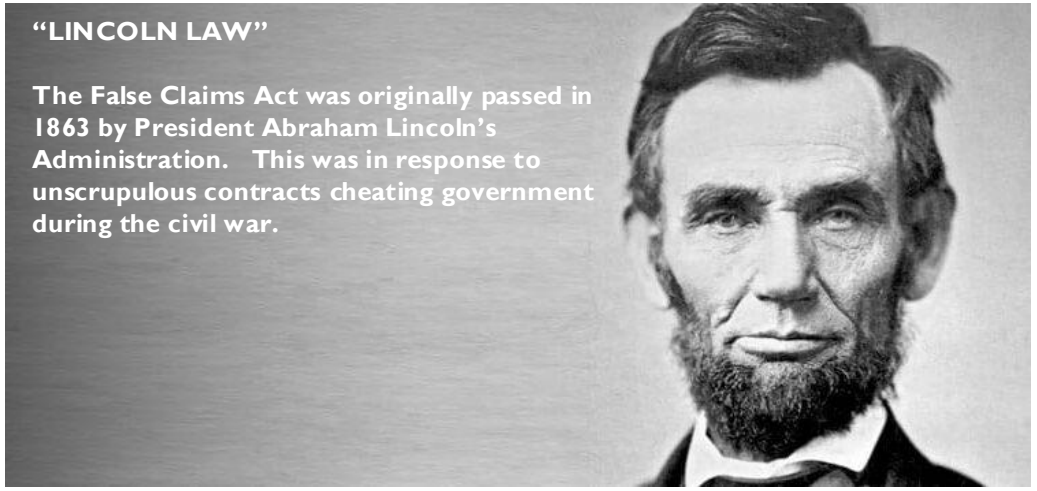


# FRAUD, WASTE, AND ABUSE (FWA)

- **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.



UMPQUA HEALTH ALLIANCE

# OREGON FALSE CLAIMS ACT (OFCA)
# &
# MEDICAID REPORTING REQUIREMENTS

UMPQUA HEALTH ALLIANCE

# EXCLUSIONS, LICENSE MONITORING, AND PROHIBITED AFFILIATIONS

# 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, which include the following:**

- UHA may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128a of the Act.
- UHA may not knowingly have a relationship with :
    1) A director, officer, or partner of UHA
    2) A subcontractor of UHA, as governed by section 438.230,
    3) A person with beneficial ownership of 5% or more of UHA's equity,
    4) 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.
    5) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No 12549 or under guidelines implementing Executive Order No. 12549.
    6) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR Section 2.101, of a person described in (1).

# 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(a)]: 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 applies to the excluded person, anyone who employs or contracts with the 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 exclusions 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 you 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, LICENSE MONITORING, 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, LICENSE MONITORING, 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.

- 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 serves 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

# 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.

# 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.*

# REQUIRED POLICY REVIEW

**Compliance Policies**

- Code of Conduct
- Compliance Program Manual
- Fraud, Waste and Abuse (FWA) Prevention Handbook
- Compliance Hotline Poster