UMPQUA HEALTH

Provider Network Policy Manual

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DEFINITIONS

Asynchronous: A method where there is no continuous real-time interaction between patient/member and provider or between providers. Asynchronous uses audio and video, audio, or text-based media and may include transmission of data from remote monitoring devices. “Asynchronous” does not include voice messages, facsimile, electronic mail or text messages.

Audio Only: The use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. “Audio only” does not include the delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

Contracted Hospital: Under Exhibit G of the CCO Contract this term means a hospital that is a subcontractor.

Contract Year: The twelve-month period during the term that commences on January 1 and runs up to and through the end of the day on December 31 on each calendar year.

Culturally and Linguistically Appropriate Care: 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.

External Personnel: Individual contracts, subcontracts, network providers, agents, first tier, downstream, and related entities, and their workforce.

Fully Dual Eligible or Full Benefit Dual Eligible (FBDE): For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the OHA for full medical assistance coverage.

I/DD: Intellectual Disability as defined in OAR 411-320-0020(21) and/or Developmental Disability as defined in OAR 411-320-0020(11).

Internal Personnel: All Umpqua Health employees, providers, volunteers, and board members.

Key Performance Indicators (KPIs): Specific elements identified by UHA (CO7 – Monitoring Policy) to track progress on whether required elements are being met.

Meaningful Access: Member-centered access reflecting the following statute / and standards:

Non-Contracted Hospital: Under Exhibit G of the CCO Contract this term means a hospital that is not a subcontractor.

Rural: A geographic area that is ten or more map miles from a population center of 40,000 people or less.

Store-and-Forward: Relating to or denoting a data network in which messages are routed to one or more intermediate stations where they may be stored before being forwarded to their destinations.

Synchronous: An interaction between a provider and a member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio and video and may include transmission of data from remote monitoring.

Telehealth: Includes telemedicine and also includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, member and professional health-related education, public health, and health administration.

Telemedicine: The mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a member's healthcare.

Trauma Informed Approach: An approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment wherein there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system. It then considers those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems can actively resist re-traumatization of the individuals being served within their respective entities.

UHA Contracted Provider: A medical, dental or behavioral health provider that has an agreement with UHA to provide covered services to their UHA members at a previously agreed upon rate for payment.

Urban: A geographic area that is less than ten map miles from a population center of 40,000 people or more.

NETWORK ADEQUACY CRITERIA

Network Adequacy Objectives

1) UHA will anticipate access needs in its provider network and will employ or subcontract, as required under 42 Code of Federal Regulation (CFR) 438.206 and under CCO Contract Exhibit B, Part 4 and any other applicable provisions of the CCO Contract, enough providers to meet the needs of UHA's members in all categories of service, and types of service providers, such that members have timely and appropriate access to services.
    a) UHA monitors to ensure that members have:
        a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services.
        b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, and behavioral health treatment.
    b) UHA will make the services it provides (including primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services or other services as necessary to achieve compliance with the requirements of 42 CFR 438, subpart K) as accessible to members for timeliness, amount, duration, and scope as those services are to other patients within the same service area.
    c) If UHA is unable to provide services through the use of participating providers qualified and specialized to treat a member's condition, we will arrange for the member to access care from non-participating providers as geographically close to the member as possible, including providers outside the service area.
    d) UHA will have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, or have behavioral health conditions, or who are children receiving Department or Oregon Youth Authority (OYA) services have access to primary care, oral care (when UHA is responsible for oral care), behavioral health providers, and referral, and involve those members in accessing and managing appropriate preventive, health, remedial, and supportive care and services. MCEs shall monitor and have policies and procedures to ensure:
        a) Access to providers of pharmacy, hospital, vision, ancillary, and behavioral health services;
        b) Priority access for pregnant women and children ages birth through five (5) years to health services, developmental services, early intervention, targeted supportive services, oral and behavioral health treatment.
    e) If necessary, UHA may contract with providers located outside of its defined service area to ensure access to an adequate provider network.
2) UHA ensures all UHA members receive the right care at the right time and place, using a patient-centered, trauma informed approach in accordance with the Oregon

Administrative Rules (OAR) 309-019-0135 and 410-141-3515, CFRs and Coordinated Care Organization Contract (CCO) Contract.

3) UHA shall make covered services available 24 hours a day, seven (7) days a week, when medically appropriate per CCO Contract.
4) Provider Network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.
5) UHA prioritizes timely access to care for prioritized populations per OAR 410-141-3515 and as outlined in Availability Standards (Priority Populations).
6) UHA ensures adequate access to all covered services for all members, including those with limited English proficiency or physical or mental disabilities. UHA takes the below into account:
   a) Anticipated Medicaid enrollment.
   b) Expected service utilization.
   c) Characteristics and health care needs of specific Medicaid populations covered in the CCO contract.
   d) The numbers, types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.
   e) The number of network providers who are not accepting new Medicaid patients.
   f) The ability of providers to communicate with limited English proficient (LEP) members in their preferred language.
   g) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities.
   h) Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits and/or other evolving and innovative technological solutions.
7) UHA will involve members in accessing and managing appropriate preventive, health, remedial, and supportive care and services.

Time & Distance Standards

UHA will monitor monthly the following time and distance standards:

1) 95% of members should be able to access the following provider and facility types within the geographic designation dependent requirements
   a) Large urban area
      (1) Tier one: 10 minutes or 5 miles
      (2) Tier two: 20 minutes or 10 miles
      (3) Tier three: 30 minutes or 15 miles
   b) Urban area
      (1) Tier one: 25 minutes or 15 miles
      (2) Tier two: 30 minutes or 20 miles
      (3) Tier three: 45 minutes or 30 miles
   c) Rural area

(1) Tier one: 30 minutes or 20 miles
(2) Tier two: 75 minutes or 60 miles
(3) Tier three: 110 minutes or 90 miles

d) County with extreme access considerations
(1) Tier one: 40 minutes or 30 miles
(2) Tier two: 95 minutes or 85 miles
(3) Tier three: 140 minutes or 125 miles

2) Below are the providers and facilities that fall into each tier
a) Tier one:
(1) Primary Care Providers serving adults and pediatrics
(2) Primary Care Dentists serving adults and pediatrics
(3) Mental health providers serving adults and pediatrics
(4) Substance use disorders serving adults and pediatrics
(5) Pharmacy
(6) Additional provider types when directed by OHA or as required by legislation

ii) Tier two:
(1) Obstetric and gynecological service providers
(2) These specialty providers, serving adults and pediatrics
(a) Cardiology
(b) Neurology
(c) Occupational therapy
(d) Medical oncology
(e) Radiation oncology
(f) Opthalmology
(g) Optometry
(h) Physical therapy
(i) Podiatry
(j) Psychiatry
(k) Speech language Pathology
(3) Hospital
(4) Durable medical equipment
(5) Methadone clinic
(6) Additional provider types when directed by OHA or as required by legislation

iii) Tier three:
(1) These specialty providers, serving adults and pediatrics
(a) Allergy and immunology
(b) Dermatology
(c) Endocrinology
(d) Gastroenterology
(e) Hematology
(f) Nephrology
(g) Otolaryngology
(h) Pulmonology

(i) Rheumatology
(j) Urology

(2) Post-hospital skilled nursing facilities
(3) Additional provider types when directed by OHA or as required by legislation

Exception Request

If UHA fails to meet one of the above standards, we will submit an exception request.

Availability Standards

UHA will monitor monthly the following availability standards:

1) Immediate Assessments
   a) Assessments on the following groups will be done immediately:
      i) Pregnant Women
      ii) Women with children
      iii) Unpaid caregivers,
      iv) Families
      v) Children ages birth through five (5) years
   b) If a timeframe cannot be met due to lack of capacity, the member shall be placed on a waitlist and provided with interim services within 72 hours of being put on a waitlist.
   c) Interim services shall be comparable to the original services requested based on the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDs testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135.
2) Emergency Care.
   a) Seen and treated immediately or referred immediately to an emergency department, depending on the member's condition (OAR 410-141-3515 (15)(a)(A)).
3) Primary Care Providers.
   a) Urgent care shall be seen within 72 hours or as indicated in initial screening in accordance with OAR 410-141-3840 (OAR 410-141-3515(15)(a)(B). Well care (aka routine) shall be seen within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through OAR 410-141-3870 (OAR 410-141-3515(15)(a)(C).
   b) Follow-up visit following an ER visit or post hospital discharge is done within 72 hours (CE29 – Transitional Care for Acute Care).
4) Specialists.
   a) Urgent care shall be seen within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840 (OAR 410-141- 3515(15)(a)(B).

b) Well care (aka routine) shall be seen within four weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141- 3860 (OAR 410-141-3515(15)(a)(C).

5) Oral Health Care Providers – Children and Non-Pregnant Individuals
   a) Emergency oral care shall be seen or treated within 24 hours (OAR 410-141-3515(15)(b)(A).
   b) Urgent oral care shall be seen within two (2) weeks or as indicated in the initial screening in accordance with OAR 410-123-1060 (OAR 410-141-3515(15)(b)(B).
   c) Routine oral care shall be seen within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate. (OAR 410-141-3515(15)(b)(C).
6) Oral Health Care Providers – Pregnant Individuals
   a) Time frame for Emergent Dental Care – Seen or treatment within 24 hours (OAR 410-141-3515(15)(c)(A));
   b) Time frame for Urgent Dental Care – within one (1) week (OAR 410-141-3515(15)(c)(B));
   c) Time frame for Initial Screening or Routine Dental Care – within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) weeks appropriate (OAR 410-141-3515(15)(c)(C)).
7) Priority Populations
   a) Priority populations must be given services within the required timeframes.
      i) If a timeframe cannot be met due to a lack of capacity, the member should be placed on a waitlist and interim services must be given.
      ii) Interim services must be comparable to those that were originally requested based on the level of care needed.
      iii) Interim services may include
         (1) Referrals
         (2) Methadone maintenance
         (3) HIV/AIDS testing
         (4) Outpatient services for substance use disorder
         (5) Risk reduction
         (6) Residential services for substance use disorder
         (7) Withdrawal management
         (8) Assessments or other services described in OAR 309-019-0135
   b) The below priority populations require immediate assessment and entry. If members must be given interim services because of capacity restrictions, treatment at the appropriate level of care must begin within 120 days from being placed on the waitlist.
      i) Pregnant women
      ii) Veterans and their families
      iii) Women with children
      iv) Families
      v) Children ages birth through five years
      vi) Individuals with HIV/AIDS or tuberculosis

vii) Individuals at risk of first episode of psychosis
viii) Individuals with intellectual or developmental disability
ix) IV drug users including heroin
(1) IV drug users must be admitted for treatment in a residential level of care within 14 days of request

c) The below priority populations will be given an assessment and entry as quickly as possible, not to exceed 72 hours
i) Members with opioid use disorder
ii) Members needing medication assisted treatment
(1) If timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on the waitlist
(2) UHA will do the following for this population:
(a) Assist members in navigating the health care system and utilize community resources such as hospitals, peer support specialists, and the like, as needed until assessment and induction can occur;
(b) Ensure providers provide interim services daily until assessment and induction can occur and barriers to medication are removed;
(c) Ensure that neither UHA or a provider requires members to follow a detox protocol as a condition of providing assessment and induction;
(d) Consider providing intensive care coordination as applicable under OAR 410-141-3870
(e) Provide members with an assessment that includes a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and the potential risks and harm to the member in light of the presentation and circumstances; and
(f) Provide no less than two (2) follow-up appointments to members within one (1) week after the assessment and induction.
iii) The below priority population will be given an assessment and entry as specified in the contract or in sub regulatory guidance:
(1) Children with serious emotional disturbance
(a) UHA will ensure that periodic social-emotional screening for all children birth through five (5) years is conducted in the primary care setting and ensure any concerns revealed by the screening are addressed in a timely manner (OAR 410-141-3515(11)(c)(B)(vi) and CCO Contract Exhibit M, Section 19(l)).

8) Routine Non-Urgent Behavioral Health Appointments for Non-Priority Populations (OAR 410-141-3515(15)(d)(C).
a) Shall be seen for an intake assessment within seven (7) days from the date of request; and

With a second appointment occurring as clinically appropriate.

9) Urgent Behavioral Health Care for all populations shall be provided within 24 hours (OAR 410-141-3515(15)(d)(A)).

10) Non-Emergent Medical Transportation (NEMT).

a) UHA ensures members have access to safe, timely, appropriate NEMT services in accordance with OAR 410-141-3920.

Interim Services

If interim services are necessary due to capacity restrictions, treatment at an appropriate level of care shall commence within 120 days from placement on a waitlist.

Emergency Care and Post-stabilization

UHA Provider Relations department is responsible for ensuring that participating providers are informed of, educated on, and monitored for compliance with UHA's policies governing emergency care and post-stabilization services. Provider Relations supports access to emergency services, appropriate provider response, and adherence to contractual and regulatory obligations as outlined in policy CE13-Emergency Care and Post-Stabilization.

1) UHA will distribute the Emergency Care and Post-Stabilization policy to all participating providers and applicable network entities, and UHA will:
   a) Ensure emergency care requirements are consistently reflected in provider-facing materials, including the Provider Handbook.
   b) Serve as a resource to providers regarding policy interpretation, expectations and regulatory requirements related to emergency and post-stabilization services.
2) UHA will educate providers on the application of the prudent layperson standard for emergency medical conditions.
   a) Inform providers that emergency services and post-stabilization services are covered regardless of network participation or prior authorization.
   b) Reinforce that emergency service claims may not be denied retroactively when a presenting condition reasonably appeared emergent.
   c) Provide guidance regarding member self-referral rights for emergency services.
3) UHA will monitor and ensure compliance to the emergency care and post-stabilization policy by:
   a) Collaborate with Compliance, Utilization Management, and Medical Management to monitor provider adherence to emergency care and post-stabilization requirements.
   b) Identify provider performance issues related to:
      - Inappropriate redirection or delay of emergency services.
      - Failure to meet access or availability standards.
   c) Follow and document corrective action plans for providers who fail to meet contractual or regulatory expectations in accordance with policy CE13-Emergency Care and Post-Stabilization (See Provider Handbook, 4.6.3, for corrective action plan).

Network Adequacy Evaluation Strategy

1) UHA will have an access plan in place. The plan will:
   a) Establish a protocol for monitoring and ensuring access.
   b) Outline how a provider capacity is determined
   c) Establish procedures for monthly monitoring of capacity and access and for improving access
   d) Establish procedures for managing access in times of reduced participating provider capacity
   e) Address the below elements:
      i) Expected utilization of services based on anticipated member enrollment and health care needs of the member population;
      ii) The number and types of providers required to furnish the contracted services based on the expected utilization of services referenced above and the number and types of providers actively providing services within the MCE's current provider network;
      iii) How UHA will meet the accommodation and language needs of individuals with LEP as defined in OAR 410-141-3500 and people with disabilities in their service area in compliance with state and federal rules including but not limited to ORS 659A, Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;
      iv) The availability of telemedicine within the provider network.
2) UHA utilizes a multi-faceted approach to evaluate its network adequacy. Specifically, UHA uses the following means to assess its network:
   a) Provider availability requirements.
   b) Time and distance standards.
   c) Member-to-Primary Care Provider (PCP) ratio.
   d) Grievance analysis.
   e) Special requests and accommodations.
   f) Utilization trends.
   g) Requests for out-of-network services.
   h) Requests for second opinions.
   i) Community Needs Assessment.
   j) Consumer Assessment of Health Care Providers and System (CAHPS) access to care and satisfaction survey results.
   k) Availability to make accommodations for physical accessibility
   l) Availability of culturally and linguistically appropriate providers
   m) NEMT call center performance and accessibility
   n) Percentage of contracted providers accepting new OHP members
   o) Wait time to appointment availability for primary care, specialty care, Oral Health, and Behavioral Health services
3) UHA will assess its network adequacy at least quarterly, and the results will be utilized to help guide its Provider Network Department of the network needs (42 CFR § 438.206)

Use of Key Performance Indicators (KPI)

1) The availability of network providers within time and distance standards.
   a) UHA will assess the geographic distribution of providers relative to members and calculate driving time and distance from the member's physical address to the provider's location through the use of AWS Location Services, a geocoding service.
   b) The geographic designation(s) will be assigned based on the following:
      i) Large urban area: conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile
      ii) Urban area: area with greater than 40,000 people within a 10-mile radius of a city center
      iii) Rural area: area greater than 10 miles from the center of an urban area
      iv) County with extreme access considerations: county with population density of 10 or fewer people per square mile
2) The adherence to standards for waiting time to appointments.
3) The availability of language services, physical access, reasonable accommodations, and accessible equipment for members or potential members with limited English proficiency or physical and mental disabilities.
   a) UHA is partners with Certified Languages International (CLI) and Linguava Interpreters Services. UHA will cover the cost for the use of language services for all eligible members including the use of Oregon certified or Oregon qualified interpreters.
   b) UHA shall ensure UHA will cover the cost for the use of language services for all eligible members including the use of Oregon certified or Oregon qualified interpreters.
   c) For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators, and cued language transliterators as defined in 45 CFR 92.4.
   d) Access-to-Care survey results and grievance data will be used to monitor language services and reasonable accommodation.

NETWORK ADEQUACY REPORTING

Monthly Reports

NEMT

1) UHA's NEMT subcontractor shall submit monthly KPIs on performance elements in order to routinely monitor the quality of the call center (CO29 – NEMT Quality Assurance Program and Plan).

Enrollment Forecasting & Utilization Planning

1) Based upon anticipated Medicaid enrollment and utilization trends, UHA measures enrollment monthly to identify fluctuations and growth patterns that could impact access to care.
   a) This data is used in real time to adjust recruitment efforts and ensure network adequacy.
   b) Predictive modeling also informs expected utilization of services in alignment with ORS 414.609.

Secret Shopper Surveys

1) UHA conducts 10 secret shopper calls per month of the following providers:
   a) PCPs
   b) Specialty providers
   c) Dental providers
   d) SUD providers
   e) Behavioral health providers
2) Random sampling will be used to choose providers.
3) Specific scenarios for each type of population requiring assessment will be used.
   a) The call scenarios are laid out in the Secret Shopper Current Call Scenarios.
4) When providers are identified as being noncompliant with the timelines, amount, duration, and scope of services (*42 CFR §438.206, OAR 410-141-3515)*, UHA will:
   a) Reach out to provider office to ensure that the data submitted is accurate.
   b) If noncompliance is confirmed, UHA will provide education on the requirements.
   c) UHA will follow up on providers who have been provided education and if noncompliance continues, UHA will do a formal written notification.
   d) If noncompliance continues after the formal notice, the provider will be placed on a corrective action plan.
   e) Corrective action plans and all follow-up actions and communications will be documented in the PR SharePoint.

Dental Access Surveys

1) Advantage Dental conducts appointment access surveys to assess compliance with dental appointment time frames.

2) The Provider Relations team will review the results.
3) If the results show that the timeliness standard is not being met, UHA Contracting and Compliance, when applicable, will be notified. Contracting and Provider Network will follow-up with Advantage Dental per the process laid out in the Compliance Program Manual.
4) The results, corrective actions, and any related follow-up will be documented in the Advantage Dental's SharePoint file.

Quarterly Reports

UHA will generate reports, at least quarterly, on the below.

Network Assessment

1. UHA consolidates the below information in order to assess the network:
    a. Anticipated Medicaid enrollment.
    b. Expected service utilization.
    c. Characteristics and health care needs of specific Medicaid populations covered in the CCO contract.
    d. The numbers, types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.
    e. The number of network providers who are not accepting new Medicaid patients.
    f. The ability of providers to communicate with limited English proficient (LEP) members in their preferred language.
    g. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities.
    h. Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits and/or other evolving and innovative technological solutions.

Access to Care Surveys

1. UHA conducts quarterly Access to Care Surveys of the following providers:
    a. PCP's
    b. Specialty providers
    c. SUD
    d. Behavioral Health
    e. Federally Qualified Health Center/Rural Health Clinic (FQHC-RHC)
2. The Provider Relations team will review the results.
3. When providers are identified as being noncompliant with the timelines, amount, duration, and scope of services, UHA will:
    a. Reach out to provider office to ensure that the data submitted is accurate.
    b. If noncompliance is confirmed, UHA will provide education on the requirements.

c. UHA will follow up on providers who have been provided education and if noncompliance continues, UHA will do a formal written notification.
d. If noncompliance continues after formal notice, the provider will be placed on a corrective action plan.
e. Corrective action plans and all follow-up actions and communication will be documented in the PR SharePoint.

Tier One Provider Reports

1) Tier one providers include:
   a) Primary Care Providers serving adults
   b) Primary Care Providers serving pediatrics
   c) Primary Care Dentists serving adults
   d) Primary Care Dentists serving pediatrics
   e) Mental health providers serving adults
   f) Mental health providers serving pediatrics
   g) Substance use disorder providers serving adults
   h) Substance use disorder providers serving pediatrics
   i) Pharmacy
   j) Additional provider types when directed by OHA or as required by legislation
2) The report on tier one providers will:
   (1) Use geomapping to determine the percentage of members within 30 minutes or 20 miles of each type of tier one provider to ensure that UHA is meeting the requirement for rural areas
   ii) Examine Member-to-PCP ratio to:
   (1) Confirm that UHA's member-to-PCP ratio does not exceed 1,500 members per PCP
   (2) Confirm that no clinic has greater than 1,500 members per PCP
   iii) Include information from available reports:
   (1) Access to Care Surveys
   (a) Percentage of contracted providers accepting new members
   (b) Wait times for new and routine appointments
   (c) Whether there is any differentiation in appointment scheduling based on type of insurance
   (d) Hours of operation
   (i) Confirm whether network providers offer hours of operation that are no less than the hours of operation that are offered to commercial members or Medicaid fee-for-service (if the provider services only Medicaid members).
   (e) Coverage of phone calls for nights, weekends, or vacations
   (f) Availability of 24-hour phone instructions or an answering service to direct patients to call 911 or go to the emergency room
   (g) Barriers to access

Tier Two Provider Reports

1) Tier two providers include:

a) Obstetric and gynecological service providers serving adults
b) Obstetric and gynecological service providers serving pediatrics
c) These specialty providers
    i) Cardiology providers serving adults
    ii) Cardiology providers serving pediatrics
    iii) Neurology providers serving adults
    iv) Neurology providers serving pediatrics
    v) Occupational therapy serving adults
    vi) Occupational therapy serving pediatrics
    vii) Medical oncology serving adults
    viii) Medical oncology serving pediatrics
    ix) Radiation oncology serving adults
    x) Radiation oncology serving pediatrics
    xi) Ophthalmology serving adults
    xii) Ophthalmology serving pediatrics
    xiii) Optometry serving adults
    xiv) Optometry serving pediatrics
    xv) Physical therapy serving adults
    xvi) Physical therapy serving pediatrics
    xvii) Podiatry serving adults
    xviii) Podiatry serving pediatrics
    xix) Psychiatry serving adults
    xx) Psychiatry serving pediatrics
    xxi) Speech language Pathology serving adults
    xxii) Speech language Pathology serving pediatrics
d) Hospital
e) Durable medical equipment
f) Methadone clinic
g) Additional provider types when directed by OHA or as required by legislation

2) The report on tier two providers will:
a) Use geomapping to determine the percentage of members within 75 minutes or 60 miles of each type of tier two provider to ensure that UHA is meeting the requirement for rural areas
b) Identify the below information:
    (1) Percentage of contracted providers accepting new members
    (2) Wait times to appointment
    (3) Hours of operation
        (a) Confirm whether network providers offer hours of operation that are no less than the hours of operation that are offered to commercial members or Medicaid fee-for-service (if the provider services only Medicaid members).
c) Include the following information for hospitals
    i) Hospital Adequacy Report:
    (1) Hospital admissions and paid amounts at contracted hospitals
    (2) Hospital admissions at non-contracted hospitals.

(3) UHA's total outpatient costs at both contracted and non-contracted hospitals.

ii) Key Performance Indicators (KPI):

(1) Data to be reported to the Compliance Department at least quarterly

(a) A minimum of 90% of UHA's total inpatient admissions, excluding all outpatient services with contracted hospitals; and

(b) A minimum of 90% of UHA's total dollars paid for all outpatient services, excluding amounts paid for inpatient admissions for all contracted hospitals.

(2) In instances where the percentage of non-contracted hospital services are below the benchmarks or the OHA's review of UHA's annual report of hospital admission by diagnosis related groups (DRG) indicates UHA's hospital network is not adequate, OHA will determine if UHA has made good faith effort to contract with the appropriate hospital(s) and OHA may modify the benchmark calculation, if necessary. The determination of good faith is based of CCO Contract Exhibit G(5)(b).

(3) If the standards are not adequately met, the Compliance Department will determine the reasoning and if necessarily, will issue a corrective action plan (Compliance Program Manual) until the required thresholds are met.

Tier Three Provider Reports

1) Tier three providers include:
   a) These specialty providers
      i) Allergy and immunology serving adults
      ii) Allergy and immunology serving pediatrics
      iii) Dermatology serving adults
      iv) Dermatology serving pediatrics
      v) Endocrinology serving adults
      vi) Endocrinology serving pediatrics
      vii) Gastroenterology serving adults
      viii) Gastroenterology serving pediatrics
      ix) Hematology serving adults
      x) Hematology serving pediatrics
      xi) Nephrology serving adults
      xii) Nephrology serving pediatrics
      xiii) Otolaryngology serving adults
      xiv) Otolaryngology serving pediatrics
      xv) Pulmonology serving adults
      xvi) Pulmonology serving pediatrics
      xvii) Rheumatology serving adults
      xviii) Rheumatology serving pediatrics
      xix) Urology serving adults
      xx) Urology serving pediatrics
   b) Post-hospital skilled nursing facilities
   c) Additional provider types when directed by OHA or as required by legislation

2) The report on tier three providers will:
   d) Use geomapping to determine the percentage of members in rural areas within 110 minutes or 90 miles of each type of tier two provider ensure that UHA is meeting the requirement for rural areas
   a) Identify the below information:
      i) Percentage of contracted providers accepting new members
      ii) Wait times to appointment
      iii) Hours of operation
         (1) Confirm whether network providers offer hours of operation that are no less than the hours of operation that are offered to commercial members or Medicaid fee-for-service (if the provider services only Medicaid members).

Grievance Analysis

1) UHA shall review all member grievances that relate to access and availability using the following process:
   a) When a grievance is received, it shall be categorized based on grievance type. The following are the grievance categories for access:
      i) Provider's office is unresponsive, not available, difficult to contact for appointment or information.
      ii) Plan unresponsive, not available, difficult to contact for appointment or information.
      iii) Provider's office is too far away, not convenient.
      iv) Unable to schedule appointment in a timely manner.
      v) Unable to be seen in a timely manner for urgent/emergent care.
      vi) Provider's office closed to new patients.
      vii) Referral or second opinion denied/refused by provider.
      viii) Referral or second opinion denied/refused by plan.
      ix) Provider not available to give necessary care.
      x) Eligibility issues.
      xi) Female or male provider preferred, but not available.
      xii) Non-emergent medical transportation (NEMT) not provided, late pick up with missed appointment, no coordination of services.
      xiii) Dismissed by provider as a result of past due billing issues.
      xiv) Dismissed by clinic as a result of past due billing issues.
   b) The number of grievances for each category shall be aggregated by quarter.
   c) The grievances shall be reviewed for trends.
      i) Individually, each category shall be reviewed for trends, such as decreases or increases in the number of that grievance or grievances originating from a particular provider, specialty, or office.
      ii) The total number of grievances in aggregate shall be reviewed for trends, such as increases or decreases in the number of grievances or similar grievances, or grievances originating from a particular provider, specialty, or office.

Special Requests and Accommodations

1) UHA shall review all member special requests and accommodations that relate to access and availability using the following process:
   a) UHA's Customer Care Department shall maintain a log of alternate format materials (MS14 – Access & Availability Language Services).
   b) Clinical Engagement also assists in special requests and accommodations related to a disability or interpretation services.
   c) The alternate format log shall be reviewed for any requests related to special requests and accommodations, including, but not limited to, those for Braille, large print, audiotape, oral presentation, and electronic format and telephone interpretation service to callers with Limited English Proficiency (LEP).
2) The interpretation requests received by Clinical Engagement shall also be reviewed.
   a) The alternate format log and interpretation requests shall be reviewed for trends, including, but not limited to, the following:
      i) A high number of requests for a provider that speaks a particular language.
      ii) A high number of requests for a service or accommodation that cannot be serviced or accommodated locally.
   b) The Oregon Administrative Rules (OAR) 950-050-0160 and Oregon Enrolled House Bill 2349 state that health care providers shall work with qualified or certified health care interpreters (HICs) from OHA's HCI central registry when arranging for or providing services to a person with limited English proficiency (LEP) or who prefers to communicate in a language other than English or who communicates in signed language.
      i) Exceptions to this rule are allowed when a provider can show proof of their language proficiency. Evidence of proficiency must be made available to OHA and relevant provider licensing and certification boards upon request.
         (1) Providers fluent in a language other than English may submit proof of language proficiency to UHQualityImprovement@umpquahealth.com. See the Clinician Language Proficiency Requirement Checklist for a full overview of language proficiency requirements. Once proof of language proficiency has been submitted, UHA will create a tag in PNDA (the provider contracting software program) so that the information is stored in the provider's file and UHA will then report proficiency information to OHA on the provider's behalf.
      ii) You can refer to the Interpreter Service Request Workflow for a list of interpreter vendors with qualified or certified HCIs offered by UHA. Providers will be reimbursed for the cost of the interpreter.

Utilization Trends

1) UHA's Utilization Management Committee shall review utilization for trends that indicate access and availability issues.
   a) UHA's utilization analysis may include, but is not limited to, the following:
      i) Utilization by specialty.
      ii) Utilization by office.

iii) Utilization by provider.
iv) Expected utilization versus actual utilization.
v) Anticipated enrollment.
vi) Requests for Out-of-Network Services
    (1) UHA shall review referrals for out-of-network referrals by provider type.
    (2) Referral requests for each provider type shall be aggregated and reviewed.
vii) Requests for Second Opinions
    (1) UHA shall review the number of requests for out-of-network second opinions.
    (2) Requests for each provider type shall be aggregated and reviewed.

Behavioral Health Dashboard

1) This dashboard is used to monitor UHA's network in order to assess availability in the following categories:
    a) Community Mental Health Programs (CMHP) or licensed behavior health treatment program under OAR 309-008-0100.
    b) Primary Care Integration.
    c) Prescribing Capabilities.
    d) Niche/Specialized Provider.
    e) Generalized Services.
2) If UHA lacks provider capacity to provide Wraparound, UHA shall notify OHA and develop a plan to increase provider capacity.
    a) Lack of capacity may not be a basis to allow members who are eligible for Wraparound supports to be placed on a waitlist.
    b) No member on a waitlist for Wraparound may be without such services for more than 14 days.

Annual Reports

NEMT

1) An annual subcontractor audit is performed in accordance with the Compliance Program Manual (Evaluation of Subcontractors section) and CO29 – NEMT Quality Assurance Program and Plan.

Cultural and Linguistic Needs Assessment

1) Per policy CA 1, UHA collects and assesses the race, ethnicity, language, gender identity and sexual orientation of its members.
2) UHA also collects network provider data at the time of initial credentialing as described in the Credentialing Manual.
3) UHA also collects complaint and grievance data related to cultural issues.
4) At least annually, UHA conducts an assessment and reports its findings. The assessment includes the following:

a) Comparison of member and practitioner race/ethnicity to ensure member needs and preferences are met with the goal to have the percentage of providers of each race/ethnicity to be within 15% from the membership percentage. The threshold will decrease by 2% every year until UHA is within 5% for each race/ethnicity of providers from the membership percentage.
b) Comparison of member and practitioner language composition to ensure member needs and preferences are met with the goal to have the percentage of providers who speak each non-English language to be within 15% from the membership percentage. The threshold will decrease by 2% every year until UHA is within 5% for each non-English language spoken by providers from the membership percentage.
c) Language assessment includes whether there is appropriate presence of bilingual staff in provider's offices and whether providers have worked with an interpreter.
d) Analysis of grievances for a specific time period (at least 12 months of data) to identify potential unmet needs and assess the network's ability to deliver culturally and linguistically appropriate care. UHA will monitor complaints/grievances at least quarterly to ensure that no more than 20% of total complaints/grievances are related to culturally inappropriate care during the calendar year (20 cultural complaints/grievances per hundred member complaints).
e) The assessment may include one or more of the following components:
    i) Providers' attitude about working with people from different cultures.
    ii) Providers' awareness of health beliefs and health-related behaviors among people from prevalent cultures in the service area
    iii) Providers' ability to determine language or cultural barriers interfering with communication.
    iv) Providers' skills in assessing patient understanding.
    v) Providers' participation in cultural humility training.

Community Needs Assessment

1) UHA will use annual assessments to examine network adequacy.
    a) UHA shall review its Community Health Improvement Plan, Community Health Assessment and Transformation and Quality Strategy for trends and issues related to access and availability to ensure UHA's provider network is capable of providing integrated and coordinated physical, oral health, behavioral health, and substance use disorders treatment services and supports as required under the CCO Contract.

CAHPS Access to Care and Satisfaction Survey

1) The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered annually by the Oregon Health Authority (OHA) on behalf of Coordinated Care Organizations (CCOs).

a) On an annual basis, UHA requests member-level CAHPS survey data from OHA. UHA analyzes the data to assess trends and identify opportunities related to access, availability, and member experience across the provider network.
b) The results of this analysis are reviewed with the Network Performance Subcommittee to support oversight of network performance and inform quality improvement activities.

2) CAHPS survey findings are used as a complementary, qualitative measure to provide a broader picture of member access and satisfaction and to guide ongoing network monitoring and improvement efforts.

Conditional Reports

Assertive Community Treatment

1) UHA will monitor and report on the members being referred and eligible for Assertive Community Treatment Services when a lack of providers is identified or when requested by OHA (OAR 410-141-3515(21).
   a) UHA shall report the number of individuals who receive employment and Supported Assertive Community Treatment services, within five (5) business days of request by OHA.
2) When a lack of appropriate providers is noted, UHA shall immediately consult with the OHA and develop an approved plan to make supported assertive community treatment services available.
   a) If 10 or more members in a CCO region have been referred, are eligible, and are appropriate for assertive community treatment, and have been on a waitlist to receive assertive community treatment for more than 30 days, CCOs shall notify OHA and take action to reduce the waitlist and serve those individuals by:
      i) Increasing team capacity to a size that is still consistent with fidelity standards; or
      ii) Adding additional assertive community treatment teams; or
      iii) When no appropriate ACT provider is available, UHA shall consult with OHA and develop an approved plan to increase capacity and add additional teams.

GAP ANALYSIS AND INTERVENTIONS

1) UHA uses the results of the assessments to determine whether there are gaps within the service area and its communities between the network's capacity and individuals' needs.
2) When gaps are identified, UHA conducts a barrier analysis to identify the barriers or root causes that are impacting the results and causing gaps in the service area.
3) UHA will further identify and prioritize the opportunities for improvement through its Network Performance (NP) Subcommittee of the UHA Quality Improvement (QI) Committee and will develop and implement interventions to address them.
    a) The Manager of Provider Relations and the Manager of Contracting will track the progress and milestones of each intervention established and provide ongoing updates to the NP Subcommittee.
4) UHA will assess the effectiveness of implemented interventions the following year to determine whether to continue with them, modify them, discontinue them and/or implement new ones for continued improvement.

Adding Providers to the Network

1) If additional in-area providers are identified that will fill a gap, Provider Network shall work to contract with them.
2) If no additional in-area providers are identified, Provider Network shall work to contract out-of-area providers to increase access if it would decrease the time or distance for members.

External Risk Response Process

1) If a provider is out of compliance with the Provider Network Manual requirements, Provider Network will notify UHA's Compliance Department.
2) UHA's Compliance Department will respond according to the Compliance Program Manual.
3) The activities of a risk response will vary depending on the issue and severity and may include a Notice of Opportunity (Notice), Opportunity Plan (OP), or a Corrective Action Plan (CAP) to remediate the provider's area of non-compliance.
    i) A CAP will be assigned to providers who do not meet the required threshold for appointment timeframes as follows (Compliance Program Manual):
        (1) Below, but within 5% of the threshold requirement for two (2) or more consecutive reporting periods.
        (2) Below and greater than 5% of the threshold requirement for one or more consecutive reporting periods.

DELEGATED ENTITIES

1) UHA retains all legal responsibility and does not have the right to subcontract the responsibility for monitoring and oversight of subcontracted activities.
2) For services delegated to a subcontractor, the subcontractor shall comply with the applicable access to care requirements as outlined in the CCO Contract and UHA's Provider Network Manual.
   a) Delegated entities should monitor their network at least quarterly to ensure compliance.
   b) Delegated entities shall provide the quarterly report to Provider Network and shall attest that they are complying with UHA's Provider Network Manual.

TELEHEALTH

General Overview

1. Information related to telehealth services may be transmitted via landlines and wireless communications, including the internet and telephone networks.
2. 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. Communications may be between providers, or between one or more providers and one or more patients, family members/caregivers/guardians.
3. UHA shall ensure that its members are offered a choice of how services are received, including services offered via telemedicine or telehealth modalities and in-person services, except where OHA issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.

Privacy and Security Standards (OAR 410-120-1990)

1. Prior to the delivery of services via a telehealth modality, a patient oral, recorded, or written consent to receive services using a telehealth delivery method in the language that the patient understands must be obtained and documented by Providers annually. Consent must be updated at least annually thereafter.
2. For limited English proficient (LEP) and deaf and hard of hearing patients and their families, providers must use qualified and certified health care interpreters when obtaining patient consent (MS14 - Access & Availability Language Services).
3. Provision of birth control information and services shall be provided to an individual regardless of age without consent of parent or legal guardian, consistent with Oregon Revised Statutes (ORS) 109.640.
4. Provision of any other medical or dental diagnosis and treatment shall be provided to an individual 15 years of age or older without consent of parent or legal guardian, consistent with ORS 109.640.
5. Services provided using a telehealth platform shall comply with Health Insurance Portability and Accountability Act (HIPAA), and with OHA's Privacy and Confidentiality Rules (Chapter 943 Division 14) except as noted in the State of Emergency section below.
6. The member may be located in the community, or in a health care setting.
7. OHP enrolled providers may be located in any location where patient privacy and confidentiality can be ensured.
8. Persons providing interpretive services and supports shall be in a location where member privacy and confidentiality can be ensured.

Provider Requirements

1. A provider needs to be enrolled with OHA as an Oregon Health Plan (OHP) provider, per OAR 410-120-1260.
2. Providers providing physical health telemedicine services must have authority to provide them. Providers performing or rendering covered physical health services hold a current and valid license without restriction from a State licensing board where the provider is located. Services via telehealth are provided within their respective certification or licensing board's scope of practice and comply with telehealth requirements including, but not limited to:
    a. Documenting member and provider agreement of consent to receive services.
    b. Allowed physical locations of provider and member.
    c. Establishing or maintaining an appropriate provider-member relationship.
    d. Correct coding standards using the most appropriate current procedural terminology (CPT) or Healthcare Common Procedure Coding System HCPCS) codes.
3. Providers are prohibited from excluding or otherwise limiting UHA members to using exclusively telehealth services, except where OHA has implemented under section State of Emergency below.
4. Providers must collaborate with members to identify methods for delivering health care services which best meet the needs of the member and considers the member's choice and readiness for the method of service selected.
5. Providers are responsible for:
    a. Complying with HIPAA and OHA's Privacy and Confidentiality Rules and security protections for the patient in connection with the telehealth communication and related records requirements (OAR chapter 943 division 14 and 120, OAR 410-120-1360 and 1380, 42 CFR Part 2, if applicable, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act) except as noted in section State of Emergency below.
    b. Obtaining and maintaining technology used in telehealth communication that is compliant with privacy and security standards in HIPAA and OHA's Privacy and Confidentiality Rules except as noted in section State of Emergency below;
    c. Develop and maintain policies and procedures to prevent a breach in privacy or exposure of member health information or records (whether oral or recorded in any form or medium) to unauthorized persons and timely breach reporting as described in OAR 943-014-0440;
    d. Maintaining clinical and financial documentation related to telehealth services as required in OAR 410-120-1360 and any program specific rules in OAR Ch 309 and Ch 410;
    e. Complying with all Federal and State statutes as required in OAR 410-120-1380.

Patient Choice and Accommodations

1. Providers shall provide meaningful access to telemedicine/telehealth services by completing capacity assessment of members in the use of specific approved method of telemedicine or telehealth assessing patients' capacities to use specific approved methods of telehealth delivery that comply with accessibility standards including alternate formats (MS14 - Access & Availability Language Services), and provides the optimal quality of care for the member given considerations of member access to necessary devices, access to a private and safe location, adequate internet, digital literacy, cultural appropriateness of telemedicine or telehealth services, and other considerations of member readiness to use telemedicine or telehealth.
2. Providers will ensure access to health care services for LEP and deaf and hard of hearing patients and their families through the use of qualified and certified health care interpreters to provide meaningful language access services as described in OAR 333-002-0040.
3. The provider's telehealth services will be culturally and linguistically appropriate using the below standards as applicable:
    a. National Culturally and Linguistically Appropriate Services (CLAS) Standards.
    b. Tribal based practice standards.
    c. Trauma informed approach.

State of Emergency

1. In the event of a declared emergency or changes in Federal requirements, OHA may adopt flexibilities to remove administrative barriers and support telehealth delivered services.
    a. OHA will follow guidance from the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) which may allow enforcement discretion related to privacy or security requirements.
    b. OHA may expand network capacity through remote care and telehealth services provided across state lines.
    c. Should OHA exercise options under a State of Emergency, UHA's obligations for Network Adequacy requirements as described in OAR 410-141-3515 remain in full effect.
    d. OHA may expand access to telehealth services for new patients.
    e. OHA may expand the definition of an establish patient-provider relationship beyond the standard of an in-person encounter every three (3) years.

Telemedicine

1. Coverage for physical health telemedicine services include:
    a. Telemedicine (synchronous audio/video visits).

        i. Telemedicine patient visits using a synchronous (live two-way interactive) video and audio transmission resulting in real time communication between a licensed health care provider and the recipient are covered when billed services comply with the guideline notes set forth by the Health Evidence Review Commission (HERC) and correct coding standards.
    b. Patient to Clinician services (electronic/telephonic).
        i. Patient to clinician services using electronic and telephone communications are covered when billed services comply with HERC guideline notes and correct coding standards.
    c. Clinician to Clinician Consultations (electronic/telephonic).
        i. Clinician to clinician consultations using electronic and telephone communications are covered when billed services comply with HERC guideline notes.
2. OHA/UHA shall provide coverage for telemedicine services to the same extent that the services would be covered if the member were provided services in person subject to the requirements outlined in the Prioritized List and associated guideline notes.

Teledentistry

1. Teledentistry can take multiple forms, both synchronous and asynchronous, including but not limited to:
    a. Live video, a two-way interaction between a patient and dentist using audiovisual technology;
    b. Store and forward, an asynchronous transmission of recorded health information such as radiographs, photographs, video, digital impressions, or photomicrographs transmitted through a secure electronic communication system to a dentist, and it is reviewed at a later point in time by a dentist. The dentist at a distant site reviews the information without the patient being present in real time;
    c. Remote patient monitoring, where personal health and dental information is collected by dental care providers in one location then transmitted electronically to a dentist in a distant site location for use in care; and
    d. Mobile communication devices such as cell phones, tablet computers, or personal digital assistants may support mobile dentistry, health care, public health practices, and education.

Telehealth Billing Requirements

1. Unless authorized in OAR 410-120-1200 Exclusions or OAR 410-120-1990, other types of telecommunications such as telephone calls, images transmitted via facsimile machines, and electronic mail are not covered:
    a. When those types are not being used in lieu of teledentistry, due to limited teledentistry equipment access; or

b. When those types and specific services are not specifically allowed in this rule per the Oregon Health Evidence Review Commission's Prioritized List of Health Services.

2. Providers billing for covered teledentistry/telehealth services are responsible for the following **(OAR 410-120-1990)**:
    a. Complying with HIPAA and OHA Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records (see OAR 410-120-1990);
    b. Obtaining and maintaining technology used in the telehealth communication that is compliant with privacy and security standards in HIPAA and Department Privacy and Confidentiality Rules;
    c. Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;
    d. Maintain clinical and financial documentation related to telehealth services as required in OARs 410-120-1360 and 410-120-1990.

Teledentistry Billing Requirements

1. The dentist may bill for teledentistry on the same type of claim form as other types of procedures unless in conflict with the Dental Services rules.
2. All Dental Services rules, criteria, and limits apply to teledentistry services in the same manner as other services.
3. All billing requirements stated in this rule apply to all delivery modalities.
4. Dentists providing Medicaid services shall be licensed to practice dentistry within the State of Oregon or within the contiguous area of Oregon and shall be enrolled as a Health Systems Division (Division) provider;
5. As stated in Oregon Revised Statutes (ORS) 679.543 and this rule, payment for dental services may not distinguish between services performed using teledentistry, real time, or store-and-forward and services performed in-person.
6. An assessment D0191 is a limited inspection performed to identify possible signs of oral or systemic disease, malformation or injury, and the potential need for referral for diagnosis and treatment. This code may be billed using the method of teledentistry:
    a. When D0191 is reported in conjunction with an oral evaluation (D0120-D0180) using teledentistry, D0191 shall be disallowed even if done by a different provider;
    b. The assessment and evaluation may not be billed or covered by both the originating site dental care provider and a distant site dentist using the method of teledentistry, even if due to store-and-forward review, if the dates of services are on different days.
7. The dentist who completes diagnosis and treatment planning and the oral evaluation also documents these services using the traditional Code on Dental

Procedures and Nomenclature (CDT) codes. This provider also reports the teledentistry event using D9995 or D9996 as appropriate.
    a. See the Dental Billing Instructions for details at: www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx;
8. The 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.
9. 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;
    a. The patient's chart documentation shall reflect notification of the right to interactive communication with the distant site dentist;
    b. 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.

Telemedicine Billing Requirements

1. UHA will only pay for services meeting all of the following requirements:
    a. Services provided shall be medically and clinically appropriate for covered conditions within the Health Evidence Review Commission's (HERC) prioritized list and in compliance with relevant guideline notes.
    b. Dependent on individual certification or licensing board's scope of practice standards, telemedicine or telehealth delivered services for covered conditions are covered for establishing a member-provider relationship, and when an established relationship exists between a provider and a member as defined by a patient who has received in person professional services from the physician or other qualified health care professional within the same practice within the past three (3) years.
    c. UHA shall provide reimbursement for services at the same reimbursement rate as if it were provided in person.
        i. Equal reimbursement also applies to interpreters.
            1. UHA agrees to reimburse Certified and Qualified Health Care Interpreters (HCIs) for interpretation services provided via telemedicine or telehealth at the same rate as if interpretation services were provided in-person, per OARs 410-141-3515(12) and 410-141-3860(12);
            2. This requirement does not supersede UHA's direct agreement(s) with providers, including but not limited to: alternative payment methodologies, quality and performance measures or Value Based Payment methods described in the CCO Contract.
            3. However, nothing in OAR 4110-141-3566 or within UHA's direct agreement(s) with providers referenced herein supersedes any Federal or State requirements with regard to

the provision and coverage of health care interpreter services.

d. When allowed by individual certification or licensing boards' scope of practice standards, telehealth delivered services for covered conditions are covered:
    i. When an established relationship exists between a provider and patient as defined by a patient who has received in-person professional services from the physician or other qualified health care professional within the same practice within the past three years; and
    ii. For establishing a patient-provider relationship.
e. All physical, behavioral and oral telehealth services except School Based Health Services (SBHS) shall include Place of Service code 02;
f. All claim types except dental services, UHA will ensure encounter submissions for telehealth and telemedicine delivered services covered using synchronous audio and video include modifiers GT or 95 and can be billed with either telephone codes (e.g. 99441) or regular in-person codes. For all telehealth services including dental, UHA shall ensure that encounter submissions include Place of Service code 02;
g. When provision of the same service via synchronous audio and video is not available or feasible (e.g. the member declines to enable video, or necessary consents cannot reasonably be obtained with appropriate documentation in member's medical record) the claim should not include any modifiers but should continue billing Place of Service as 02.

2. Unless authorized in OAR 410-120-1200 Exclusions, other types of telecommunications are not covered, such as telephone calls without medical decision making, images transmitted via facsimile machines and electronic mail.
3. During an outbreak or epidemic, OHA/UHA shall provide coverage and reimbursement of patient to clinician telephonic and electronic services for established patients using the Division's maximum allowable rate setting methodology:
    a. Relative Value Unit (RVU) weight-based rates for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes assigned an RVU weight are calculated on the current year's published value multiplied by a state-wide factor.
    b. The Division may reimburse telephonic and electronic services to the same extent that the services would be covered if they were provided in person consistent with HERC guideline notes.

ADDING NEW PROVIDERS

Process to Add New Provider

1. UHA collects provider data through the Contracting and Credentialing process.
    a. UHA uses the Provider Request Questionnaire to collect information.
    b. Please refer to the Credentialing Manual for further details.
2. After a provider is approved through the Credentialing Committee to join the UHN, the Provider Relations department is notified.
    a. a. The Provider Relations department receives the credentialing files for the newly credentialed providers and enters provider updates in the provider database.

Provider Directory Updates

1. The provider directory must be updated within 30 days of notice of change in both the electronic and the PDF printable version. Both versions are available through UHA's OHP member page and the dropdown menu by selecting "Find A Provider" on umpquahealth.com.
2. Subcontractor delegated credentialing must submit a monthly delegated provider roster to Provider Relations to ensure timely updates are made to the PDF printable and online directory.
    a. Provider Relations in conjunction with the Compliance Department will follow the procedures outlined in the Compliance Program Manual (External Risk Response Process section) if subcontractor is not complaint with timely roster submissions.
    b. Provider Relations department receives, validates, and enters the data from each roster into the provider database to ensure the UHA's PDF printable and online directories are up to date.
3. The UHA website is updated as needed, and changes are made at minimum within a week of receiving notice.
    a. Provider updates may be prompted when a provider's information changes, that include:
        i. Any of the data points listed under Provider Types and Data Points of this policy;
        ii. Retires from practice;
        iii. Involuntarily discharged; or
        iv. Ceases UHN participation.

b. Updates are submitted by the Credentialing Specialist or by a provider/provider group to the Provider Relations department to ensure the PDF printable and online provider directory is updated within 30 days of receiving the notice.
c. Provider update activities are tracked using PNDA. Upon receipt of an update, Provider Relations personnel document the type of update and the date it was received. Reports may be generated to compare the date of receipt with the date the change was implemented, ensuring that all updates are completed within 30 days of receipt.

4. The provider directory will be maintained and available on the UHA website, including a machine-readable file and format per 42 CFR §438.10(h)(4).
a. Access to modify, change, and publish the provider directory on the website is limited to the authorized Credentialing and Provider Relations staff.

Provider Types and Data Points

1. The provider directory covers each of the following provider types covered under the contract:
    a. Physicians, including specialists;
    b. Hospitals;
    c. Pharmacies;
    d. Dentists;
    e. Dental and Oral Health Providers;
    f. Behavioral Health Providers; including specifying substance use treatment providers and facilities.
    g. NEMT (Non-Emergent Medical Transportation) Providers; and
    h. LTSS (Long-Term Services and Supports) Providers, as appropriate.
2. Information maintained on the provider directory includes the following data points as applicable. The data points are searchable and machine readable both online and in the PDF form:
    a. Last name of physician or mid-level practitioner;
    b. First name of physician or mid-level practitioner;
    c. Individual provider specialty type;
    d. Name and any group affiliation associated to provider;
    e. Provider's race and ethnicity;
    f. Non-English language spoken and information on cultural and the linguistic capabilities (including Sign Language) offered by the Provider, the practice' staff or an OHA approved Qualified and, as applicable, Certified Health Care Interpreter(s) at the Provider's office;
    g. Whether the provider has a verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing)
    h. Whether the provider has completed cultural competence training as required by ORS 413.450 and in accordance with CCO Health Equity Plan Training and Education plan;

i. How to request free oral and written language interpreting services (including Certified and Qualified Health Care Interpreters, and a sign language interpreter) from provider;
j. Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;
k. Information on office/facility's accommodations for people with physical disabilities, including offices, exam room(s) restrooms, and equipment;
l. Facility name;
m. Address;
n. City;
o. Zip code;
p. Phone and fax;
q. Office hours of operation;
r. Offers telehealth, and in-person visits;
s. Website URL, as applicable;
t. Open to new members;
u. Age range of patients served; and
v. In-network, out-of-network.

Monitoring and auditing of timeliness of provider directory updates

1. Responsible parties will maintain a tracking system to illustrate that UHA is meeting the requirement of updating the provider directory within 30 days of a provider joining the network or a provider change is received.
    a. PNDA (UHA's Provider Database) will be used as a tracking method for updating the electronic provider directory within 30 days of notification of a change from a provider.
    b. For detailed monitoring process see Provider Directory Updates and Monitoring Standard Operating Procedure (SOP).

Member Distribution

1. Members and potential members will receive a written notice through UHA's Member Handbook noting the location of the provider directory on UHA's website.
    a. Members and potential members also have the option to contact UHA's Customer Care to obtain copies in another language, large print, Braille, CD, tape or another alternate format (MS14 – Access & Availability Language Services, MS12 - Americans with Disabilities Act and Members, and MS13 - Section 1557 of the Patient Protection and Affordable Care Act and Members).
    b. a. A copy is available upon request at no cost to the member or potential member.

PROVIDER SELECTION

Request to Join

1. Providers may request to join UHA's network at any time.
2. Upon request to join the network, UHA's Provider Network Department will submit a questionnaire for the provider to complete.

Provider Review

1. UHA's Provider Network Department will review the questionnaire and decide as to whether to contract with the provider.
2. UHA shall screen their participating providers according to the Credentialing Manual and the regulations (42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470). All resulting documentation will be retained for audit purposes in accordance with CO23 – Record Retention and Destruction.
    a. This rule doesn't apply when credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines or the administration of the flu vaccine when administered in conjunction with the COVID-19 vaccine.
        i. COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the OHA's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.
3. UHA is prohibited from:
    a. Denying network participation on the basis of a provider's license or credentials (OAR 410-141-3510(2) and 42 CFR 438.12) or that they serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 438.214).
    b. Applying any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.
    c. Requiring the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.
4. UHA shall offer contracts to all Medicaid eligible IHCPs and provide timely access to specialty and primary care within its networks to Medicaid enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the network in accordance with OAR 410-141-3510(8).

5. UHA rationale for denial may include but is not limited to the following reasons:
    a. Network is at capacity.
    b. Quality concerns.
    c. Limited historical services performed by the applicant.
    d. Duplicate services with other contracted providers.

Provider Notification

1. If UHA decides to add the provider into the network, UHA will notify the provider in writing of the decision and begin the contracting process.
2. If UHA decides to deny a provider's application to join its network, UHA will provide a written notice to the provider.
    a. The written notice shall include:
        i. Reason for UHA's decision to deny participation.
        ii. A brief explanation that providers may serve UHA's members on a case-by-case basis through the prior authorization process, as permitted by regulatory requirements.
        iii. Provide a dispute resolution process, including the use of an independent third party arbitrator, for a Provider's refusal to contract with Contractor or for the termination, or non-renewal of a Provider's contract with Contractor, pursuant to OAR 410-141-3560.
        iv. UHA's Provider Network Manual (Provider Selection).

Discrimination

1. Providers may file an appeal in the event they believe that UHA discriminated against him/her during the application process (OAR 410-141-3510(3)(4)).
    a. To file an appeal, providers will be requested to supply in writing the rationale as to why they feel that discrimination occurred.
    b. Providers will be permitted to supply supporting documentation to UHA's Credentialing Committee who will conduct the internal review.
2. Once the appeal request is complete, it will be submitted to UHA's Credentialing Committee for review.
    a. UHA's Credentialing Committee will review the appeal and support documentation submitted by the providers.
    b. The Credentialing Committee will then determine if there is evidence of discriminatory practices by UHA and notify the provider in writing of the decision.

PROVIDER TRAINING

Curriculum and Cadence

As part of UH's provider orientation process, providers shall be given a current copy of the Provider Orientation Slide Deck, the Provider handbook and the Member Handbook.

a. The Provider Orientation Slide Deck includes links to the following policies:

I. CE01 - Grievance Appeals and Hearings
II. CE03 - Wraparound
III. CE11 - Covered Services
IV. CE12 – Prior Authorizations
V.CE19 - Substance Use Disorder Services
VI. CE21 - Adverse Benefit Determinations
VII. CE22 - Payment and Authorization of Hospital Admissions
VIII. CE28 - Transition of Care
IX. CR13 -
X. F18 - Third Party Liability Recovery (TPLR)
XI. MS1 - Member Assignment and Reassignment
XII. MS2 – Nondiscrimination of Members
XIII. MS3 - Member Rights, including information pertaining to:
    a. Access to records
    b. Ability to amend or correct records
    c. Right related to respect, dignity, and privacy
    d. Appropriate use of seclusion and restraints
    e. Right to receive culturally and linguistically appropriate services and supports, including Qualified Healthcare Interpreter Services
XIV. PN6 - Provider Orientation and Training
XV. PN7 - Network Adequacy
XVI. PN8 - Monitoring Network Availability
XVII. PN9 - Monitoring Network Access

b. –Compliance Program as specified in UH internal documentation:

I. UHA's Compliance Program Manual
II. UHA's Fraud, Waste, and Abuse (FWA) Prevention Handbook
III. UHA's Code of Conduct
IV. UHA's Hotline Reporting Poster

2. Instructions on accessing the Provider Orientation and Training material via the UH website shall be provided immediately following the executed provider agreement, but no more than 30-days from the completion of the contract process.

c. When substantial changes are made to training materials, providers will be notified via the Provider Resource page on the UH Website.

Documentation of Completion

1. All providers that are contracted with UHN are to complete the provider orientation trainings and any subsequent re-orientations or annual trainings, as necessary.
2. Upon completion of the Provider Orientation and Training material, each provider must sign an attestation that he or she has been informed about the information provided during the orientation and agrees to comply with all of UHA's policies and procedures and training requirements as outlined in the CCO Contract.
3. The UHA Provider Training Tracking Log will be used to monitor the distribution and receipt of orientation and training materials.
    a. Each entry shall include:
        i. The office and/or provider name;
        ii. The method of notification;
        iii. Date of notification or mailing; and
        iv. Receipt date of attestations.
    b. Materials tracked include but are not limited to:
        i. Provider Handbook at time of onboarding.
        ii. Notification that an updated version of the Provider Handbook is available on the UHA website (occurs when substantial changes have been made).
        iii. Notification and listing of required trainings.
4. Periodic provider trainings and orientations will be provided as needed to inform existing providers of updates to Members' rights and UH's policies and procedures.
    a. Any updates will provided through UH's Provider Newsletter, email notifications, and/or in person
    b. A record of the trainings and orientations shall be maintained by Provider Network.

Training Monitoring

1. In the event that during the monitoring process, it is determined a provider is out of compliance with the required trainings, Provider Network will notify UHA's Compliance Department.
    a. UHA's Compliance Department will assign one of the below in order to remediate the provider's area of compliance:
        i. Notice of Opportunity (Notice)
        ii. Opportunity Plan (OP)
        iii. Corrective Action Plan (CAP)
    b. Actions will follow the Compliance Program Manual – (External Risk Response Process section).

c. The activities of a risk response will vary depending on the issue and severity.

Provider Handbook Review and Update

1. Annually, or sooner if needed, UHA will periodically review its Provider Handbook.
2. During the fourth quarter of each year, the Provider Relations department will review the Provider Handbook and, if needed, collaborate with other departments for appropriate updates.
    a. Feedback from each department Director is received and collated in a draft form for further review by additional departments that may be affected and sent for final approval from the Chief Medical Officer.
3. Once the new Provider Handbook is approved, UHA:
    a. Uploads the new version to the UHA website.
    b. Informs each UHA provider in writing that the new version is available
4. A copy of current and previous versions is archived in a shared network folder.

PROVIDER RETENTION

1. In accordance with 42 CFR §438.214(a) and OAR 410-141-3510, Umpqua Health Alliance (UHA) maintains strategies and internal processes to support the retention of high-quality, culturally competent, and accessible network providers.
2. These efforts are designed to ensure continuity of care, minimize member disruption, and preserve network adequacy and stability.

Retention Strategies

1. Provider Engagement and Feedback:
    a. UHA solicits regular feedback from contracted providers through satisfaction surveys, Provider Advisory Committee meetings, and direct outreach.
    b. Feedback is analyzed and used to inform quality improvement efforts and strengthen provider relationships.
2. Support and Education:
    a. UHA offers training and technical assistance on regulatory compliance, quality measures, documentation standards, and culturally and linguistically appropriate service delivery.

Monitoring and Early Intervention

1. UHA monitors the following to identify trends that may impact provider retention:
    a. Trends in credentialing timelines
    b. Provider complaints
    c. Access concerns
    d. Termination notices
2. Early interventions are deployed when indicators of dissatisfaction or network risk are observed.
    a. Performance Recognition and Incentives:
        i. UHA participates in the Oregon Health Authority's Quality Incentive Program (QIP), issuing performance-based incentive payments to providers who meet or exceed established clinical and access benchmarks.
            1. Measures may include:
                a. Timeliness of prenatal and well-childcare
                b. Emergency department utilization rates
                c. Diabetes and hypertension control
                d. Adolescent well-care visits
                e. Member satisfaction metrics

2. These incentives serve as both recognition and motivation for ongoing participation in the network.

ii. UHA supports Patient-Centered Primary Care Home (PCPCH) certification among its contracted providers.
    1. Support includes:
        a. Tiered financial incentives based on PCPCH tier (Tier 1 through Tier 5)
        b. Technical assistance for achieving and maintaining certification
        c. Access to pilot initiatives and care coordination programs
        d. Recognizing and rewarding PCPCHs aligns with UHA's broader goals of advancing member-centered, coordinated care.
        e. Exit Feedback and Continuous Improvement:
            i. When a provider exits the network, UHA may conduct exit interviews or request feedback to identify any systemic or preventable issues contributing to termination. Findings are used to adjust policies, outreach, and provider support approaches.

iii. UHA documents all provider retention efforts and presents updates and trends to internal committees, including the Network Performance Subcommittee and Credentialing Committee. Provider retention and satisfaction are key components of UHA's network sufficiency and DSN monitoring activities.

3. When needed, individualized support is provided to providers at risk of disengagement or termination due to performance or administrative issues.