Provider Manual

Healthier Together

Samaritan Health Plans

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Section 1: Introduction

1.1 About us

Samaritan Health Plans (SHP), headquartered in the beautiful Willamette Valley, is part of an extensive network of hospitals, doctors, clinics and caring professionals who work in tandem to provide organizations and individuals with the best care and service possible. Since 2013, Samaritan Health Services (SHS) has been ranked in the top three Healthiest Employers in Oregon according to the Portland Business Journal and one of the top 100 healthiest places to work in the U.S. At SHP and SHS, we take wellness seriously and we're proud of our award-winning commitment.

As a dedicated wellness organization, we believe in giving our members a greater role in their health. We believe in our own advice, using our self-funded plan for our own employees as a proving ground for new approaches to nurturing workplace wellness and individual well-being. And we believe in providing local and regional coverage that understands being well embodies the whole person – body, mind, spirit, environment, work, emotions, finances and community, which are the eight aspects of wellness.

Today, health care faces many challenges. We are rising to meet those challenges, but not alone. We are proud of the work we are doing with our clinician partners towards achieving the triple aim for health care: lower costs, better care, better quality. And we are thankful for the thousands of individuals and businesses that have placed their faith in us, realizing we are reliant on each other for greater outcomes. Each succeeding when the other does. Working together towards the same goals, towards new heights.

Mission

Building Healthier Communities Together

Vision

Serving our communities with PRIDE

Values

Pride

Respect

Integrity

Dedication

Excellence

1.2 About this manual

Samaritan Health Plans has developed this manual for our contracted providers. The Provider Manual along with your contract, should offer guidance and resources that will aid you in providing care to your patients/ our members. This manual provides crucial information concerning the role and responsibilities of the provider in the delivery of health care to our members and your patients. If you are reviewing a print copy of this manual, please note that content is subject to change and you should refer to the Provider Manual on the Samaritan Health Plans website for the most current information. samhealthplans.org/ProviderManual.

In addition, we suggest you visit our website at providers.samhealthplans.org to find other helpful tools such as provider directories, member benefits and current announcements.

1.3 Lines of business

Samaritan Advantage Health Plans

Samaritan Advantage Health Plans (HMO) (SAHP) offers four plans to eligible members: Conventional Plan, Premier Plan, Premier Plan Plus and the Special Needs Plan (SNP).

Conventional Plan (HMO) is for eligible members who have decided not to participate in Medicare Part D. These members may not enroll in a stand-alone Prescription Drug Plan (PDP). This plan offers Original Medicare benefits and some supplemental benefits.

Premier Plan (HMO) offers a prescription benefit (Medicare Part D) in conjunction with Original Medicare benefits and a variety of supplemental benefits.

Premier Plan Plus (HMO) is the enriched Advantage plan, offering the most supplemental benefits. It offers all the benefits of the Premier Plan, plus more: dental benefits, hearing aids, free Silver & Fit membership and coverage during the Medicare Rx drug coverage gap for some tiers.

Special Needs Plan (HMO) is for Medicaid eligible members who are also eligible for Medicare Part A and Part B. These members are dually enrolled in Medicaid and Medicare and are referred to as "duals". They have both medical benefits and prescription drug benefits.

All SAHP plan benefits are subject to review for medical necessity via written documentation or appropriateness of treatment setting (level of care versus severity of condition).

Providers are required to verify that the patient is eligible on the date of service before rendering services and that the service is covered under the Samaritan Advantage Health Plans. The provider is required to seek any necessary prior authorizations. Finally, providers must inform SAHP members of any non-covered services prior to being delivered and must inform members of their responsibility for payment of these services.

Providers contracted with SAHP can be found through the searchable directory at providers.samhealthplans.org/Refer-for-Care.

SAHP members have rights and responsibilities as described in the "Your rights and responsibilities" chapter of the Evidence of Coverage. The Evidence of Coverage for each Advantage plan can be accessed at samhealthplans.org/2022Benefits. You can also find this information in the member rights and responsibilities section of this manual.

InterCommunity Health Network Coordinated Care Organization

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) was formed in 2012 by local public, private and nonprofit partners to unify health services and systems for Oregon Health Plan (OHP) members in Benton, Lincoln and Linn counties. Although IHN-CCO's contract with the state of Oregon is not exclusive, it is currently the only CCO in these three counties that administers OHP, which provides access to health insurance for Medicaid-eligible, low-income residents.

IHN-CCO offers three packages for members, depending on the level of care individual members need: comprehensive (medical, mental health and dental), mental health and dental and mental health only. Find out more about plan benefits at IHNtogether.org/Your-Benefits.

IHN-CCO uses the OHP Prioritized List of Health Services, a listing of diagnosis and treatment pairings, to determine whether a diagnosis and/or service is part of the OHP benefit package.

The Oregon Health Services Commission (HSC) designs and maintains the prioritized list under the direction of the Oregon Legislature. The legislature determines the level to which the list will be funded. Diagnoses and/or treatments that are considered **below the line** are not funded by the available budget set forth by the Oregon Legislature and are therefore not considered part of the OHP benefit package. IHN-CCO plan benefits are subject to review for medical necessity via written documentation, appropriateness of treatment setting (level of care versus severity of condition) and the OHP Prioritized List condition/treatment pair ranking. For **above and below the line** diagnoses, please refer to the OHP Prioritized List of Health Services at oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx.

Contracted providers can be found in the searchable provider directory at providers.samhealthplans.org/Refer-for-Care.

IHN-CCO members have rights and responsibilities as described in the IHN-CCO Handbook. The handbook can be accessed at: providers.samhealthplans.org/Handbook. You can also find this information in the member rights and responsibilities section of this manual.

Samaritan Choice Plans

Samaritan Health Services (SHS) offers Samaritan Choice Plans (SCP). These are the self-funded health benefit plans that provide coverage for Samaritan employees and their dependents.

Samaritan Choice Plans offer a standard medical plan, an HSA eligible high-deductible medical plan and a vision plan. A pharmacy plan is included with both medical plans. View plan benefits and access our provider directory at providers.samhealthplans.org/Refer-for-Care.

Choice members have rights and responsibilities as described in the Samaritan Choice Medical and Pharmacy Handbook and the Samaritan Choice Vision Handbook. For the most up-to-date language, the handbooks can be accessed on the Samaritan website at choice.samhealthplans.org/2022ChoiceBenefits. You can also find this information in the member rights and responsibilities section of this manual.

Samaritan Employer Group Plans

Samaritan Health Plans (SHP) offers employer group health plans to businesses domiciled in the state of Oregon. View benefits for small, large and association group plans at samhealthplans.org/Employers.

You can view all preferred providers in the provider directory by visiting our website at providers.samhealthplans.org/Refer-for-Care.

Samaritan employer group plans members have rights and responsibilities as described in their group certificates. You can find this information in the member rights and responsibilities section of this manual.

Section 2: Contact us

SHP **Customer Service** is available to provide assistance Monday through Friday, from 8 a.m. to 8 p.m. Our representatives can:

- Assist with member eligibility and benefits.
- Provide claims assistance.
- Accept grievances and concerns.
- Answer questions regarding authorizations.

Phone:

Monday through Friday, from 8 a.m. to 8 p.m. at **541-768-5207** or toll free **888-435-2396**.

Mail:

Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

In-person:

Monday through Friday, from 8 a.m. to 5 p.m.
2300 NW Walnut Blvd., Corvallis, OR 97330

Contact us by phone at the Customer Service number or by email:

healthplanresponse@samhealth.org

Our **Provider Relations** team is here to assist you with:

- Credentialing questions.
- Contracting (existing or new).
- Provider education and training.
- Samaritan Health Plans provider portal: Provider Connect.

Section 3: Claims

3.1 Eligibility and benefits

Eligibility and benefit information for our members can be accessed via SHP's provider portal, Provider Connect, or through our Customer Service Department. Except for emergency services and as applicable, the provider shall verify each member's eligibility prior to rendering any services.

3.2 General claims information

Providers are responsible for submitting itemized claims for services provided to members in a complete and timely manner, in accordance with your provider agreement, this manual and applicable law. Providers are also responsible for ensuring that all codes submitted to SHP for payment are current and accurate, that the codes reflect the services provided and are compliant with all industry and governmental standards. Incorrect or invalid coding may result in delays in payment, denial of payment, a post-payment provider refund request or a post-payment recoupment of overpaid amounts from later payments.

SHP reserves the right to review all claims submitted for accuracy and appropriateness. This review may include review of supporting documentation. Improper data submission may cause claims to pend and/or be returned for correction or documentation.

3.3 Oregon Medicaid Registration

The Oregon Health Authority (OHA) requires all providers who submit claims to Oregon Coordinated Care Organizations to be registered with the Oregon Medicaid office prior to receiving payment for services. If you have not registered, you must submit application materials and receive an Oregon Medicaid ID number before we can pay you. See oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx for forms and process.

3.4 Electronic claims submission

SHP encourages providers to submit claims via Electronic Data Interchange (EDI) for quicker claims reimbursement, improved accuracy and to reduce or eliminate costs associated with mailing, such as envelopes and postage. To sign up for EDI, visit our billing and claims page at providers.samhealthplans.org/Submit-Claims.

3.5 Electronic funds transfer (EFT)

Samaritan Health Plans recommends that providers receive payment via electronic funds transfer (EFT) for quicker payment and to avoid lost checks. Funds are deposited directly into your designated bank account and include the reassociation trace number (TRN), in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions. Additional benefits include:

- Accelerated access to funds with direct deposit into your existing bank account.
- SHP administrates payments for IHN-CCO. By signing up with InstaMed, you will receive SHP payments and those for the IHN-CCO members you see.

- Reduced administrative costs by eliminating paper checks and remittances.

SHP has partnered with InstaMed to deliver this simplified payment experience.

To sign up and begin receiving electronic funds transfers (EFT), contact InstaMed at:

Online: Visit InstaMed.com/ERAEFT

Phone: Call InstaMed at **866-945-7990** to speak with an agent.

3.6 Electronic remittance advice

Providers can also choose to receive free electronic remittance advice (ERAs) for Samaritan Health Plan payments. ERAs can be routed to your existing clearinghouse through our partner InstaMed.

To sign up and begin receiving ERAs, contact InstaMed at:

Online: Visit InstaMed.com/ERAEFT

Phone: Call InstaMed at **866-945-7990** to speak with an agent.

3.7 Paper claims submission

For providers who submit paper claims please refer to the following standards to produce clean and legible claims, which will reduce claim rejection, speed up processing and prevent payment delays:

If you need help filling out the CMS 1450 or 1500 form, please see providers.samhealthplans.org/submit-claims to review form requirements and guides.

- Submit only claim forms that are typed or printed.
- Correctly align text in the form boxes and do not allow text to overlap lines.
- All claims and attachments should be printed single sided. Do not duplex print, even on primary Explanation of Benefits (EOBs) or attachments.
- Send full page attachments only.
- Do not staple claims or attachments together.
- Mark multi-page claims with either a page number, i.e., page 2 of 3, or as continued.
- Ensure that each secondary claim has the primary EOB submitted with it.
- Do not write or stamp over top of the body of the claim form.
- Do not use white-out or cross out and correct any fields that affect the payment of the claim.
- Use black ink — the scanning process filters out red ink.
- Use the remarks field for messages.
- Send the original claim form to Samaritan Health Plans and retain a copy for your records.
- To help our equipment scan accurately, remove all perforated sides from the form. Leave a quarter-inch border on the left and right sides of the form after removing perforated sides.
- Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
- Print with dark font. Ensure your toner or ink is fresh and please do not print in draft mode.

Where to mail paper claims

Please see providers.samhealthplans.org/Submit-Claims and choose File by Mail to access our current mailing addresses by line of business.

If you submit paper claims, the following information must be included:

- Provider name.
- Rendering provider, group or billing provider.

- Federal provider TIN.
- NPI (excluding atypical providers).
- Medicare number (if applicable).
- DMAP number (if applicable).

Some claims may require additional attachments. When submitting a paper claim, please include all supporting documentation. Claims with attachments should be submitted on paper and attachments should be printed single sided. Claims with duplex printed attachments may be sent back for correction and resubmission.

3.8 Monitoring submitted claims

After filing a clean claim, the claim status should be available in our claims adjudication system within 10 to 14 business days after receipt. After filing a clean electronic data interchange (EDI) claim, the claim status should be available in our claims adjudication system within two business days of receipt.

After submitting paper or electronic claims, you can monitor them by:

- Checking claim status on our secure provider portal at providerconnect.samhealth.org. Users must be subscribers of OneHealthPort in order to login. If you are not yet subscribed to OneHealthPort, please register your organization at onehealthport.com/sso/register-your-organization. Providers that are not subscribed should click on "I'm not an OneHealthPort Subscriber but would like information on subscribing".
- Contacting Customer Service at providers.samhealthplans.org/Contact-Us.
- Confirming receipt of plan batch status reports from your vendor or clearinghouse to ensure your claims have been accepted by SHP.
- Correcting and resubmitting plan batch status reports and error reports electronically.
- Correcting errors and immediately resubmitting to prevent denials due to late filing.

3.9 Claims editing and pricing

SHP uses claims editing software developed internally and from third-party vendors to assist in determining the appropriate handling and reimbursement of claims. From time to time, SHP may change this coding editor or the specific rules that it uses in analyzing claims submissions. SHP's goal is to make sure claims are accurate and to ensure compliance with all state and federal rules and regulations, including those claims payment methodologies required for Medicare Advantage and OHP administration.

SHP utilizes both the Optum EASYGroup Prospective Payment Systems (PPS) and the Claims Editing System (CES) software to ensure accuracy and consistency in claims processing for all of our product lines for both professional and facility-based claims.

This system applies all the existing industry standard criteria and protocols for Diagnosis Related Groups (DRG), Current Procedural Terminology (CPT), Healthcare Procedure Coding System (HCPCS) and the Internal Classification of Diseases (ICD-10_CM) manuals.

The three most prevalent coding irregularities we find are:

- **Unbundling:** Two or more individual CPT or HCPCS codes that should be combined under a single code or charge.
- **Mutually exclusive:** Two or more procedures that by practice standards would not be billed to the same patient on the same day.

- **Inclusive procedures:** Procedures that are considered part of a primary procedure and not paid as separate services.

Consistent application of these rules improves the accuracy and fairness of our payment of benefits.

The software also applies the National Correct Coding Initiative (NCCI) edits for the processing of both facility and professional claims. Our updates of the NCCI are implemented as soon as possible after receipt from Optum. However, these updates will not align with CMS; we will always be one version behind.

3.10 Prompt payment

Samaritan Health Plans follows CMS and OHA guidance to determine claims payment timeliness for Medicare and Medicaid lines of business. These guidelines can be found in the following documents for Medicare:

- Review at the Medicare Managed Care Appeals & Grievances webpage at cms.gov/Medicare/Appeals-and-Grievances/MMCAG.
- Medicare Claims Processing Manual Chapter 1, Sections 80.2 and 80.3. cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
- Prioritized List and Guideline Notes found at oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx.

3.11 Coordination of benefits and third-party liability

SHP follows the National Association of Insurance Commissioners (NAIC) model regulations for coordinating benefits, except in instances where the NAIC model regulations differ from Oregon state law or from CMS regulations.

In order to identify all third-party payers, IHN-CCO requires all providers to request and obtain information about third-party liability (TPL) for payment of services and any and all other insurance coverage to which an IHN-CCO member may be entitled and to provide such information to IHN-CCO within 30 days of discovery. Samaritan Health Plans also requires IHN-CCO contracted providers to comply with OHA requests for third-party eligibility information in a timely manner. The following information should be collected and emailed to the TPL department at shpthirdpartyinvestigation@samhealth.org:

a. The name of the third-party payer, or in a case where the third-party payer has insurance to cover the liability, the name of the policy holder.
b. The member's relationship to the third-party payer or policy holder.
c. The social security number of the third-party payer or policy holder.
d. The name and address of the third-party payer or applicable insurance company.
e. The policy holder's policy number for the insurance company.
f. The name and address of any third-party who injured the member.

3.12 Balance billing

Samaritan Advantage Health Plans

The Qualified Medicare Beneficiary (QMB) Program is available to assist low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost sharing, including deductibles, coinsurances and copayments.

Federal law (Sections 1902(n)(3)(B) and 1866(a)(1)(A) of the Act, as modified by Section 4714 of the Balanced Budget Act of 1997) prohibits all Medicare providers from billing QMBs

for all Medicare deductibles, coinsurance, or copayments. All Medicare and Medicaid payments you receive for furnishing services to a QMB are considered payment in full.

InterCommunity Health Network Coordinated Care Organization

A provider who is rendering services to an InterCommunity Health Network CCO (IHN-CCO) member:

- May not seek payment from the member for any Medicaid-covered services.
- Cannot bill the member for a missed appointment.
- May not bill the member for services or treatments that have been denied due to provider error.
- Cannot bill IHN-CCO more than the provider's usual charge.

A provider may only bill an IHN-CCO member in the following situations:

- Any applicable coinsurance, copayment and deductibles expressly authorized in OAR chapter 410, divisions 120 and 141 or any other Division program rules.
- The member did not inform the provider of their OHP coverage at the time of or after service was provided; therefore, the provider could not bill the appropriate payer for reasons including but not limited to the lack of prior authorizations or the time limit to submit the claim for payment has passed. The provider must verify eligibility and document attempts to obtain coverage information prior to billing the member.
- The member became eligible for benefits retroactively but did not meet all the criteria required to receive the service.
- A third-party payer made payments directly to the member for services provided.
- The member has the limited Citizen Alien Waived Emergency Medical (CAWEM) benefit package. CAWEM members have the benefit package identifier of CWM. Members receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits. (See OAR 410-120-1210 for coverage.) The provider must document that the member was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is not required for these services.
- The member has requested a continuation of benefits during the contested case hearing process and the final decision was not in favor of the member. The member shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (3)(h) of this rule before providing these services.
- In exceptional circumstances, a member may decide to privately pay for a covered service. In this situation, the provider may bill the member if the provider informs the member in advance of all the following:
  - The requested service is a covered service and the appropriate payer (the Health Systems Division, Managed Care Entity (MEC), or third-party payer) would pay the provider in full for the covered service. The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service and that the provider cannot bill the member for an amount greater than the amount the appropriate payer would pay.
  - The member knowingly and voluntarily

agrees to pay for the covered service.

  - The provider documents in writing, signed by the member or the member's representative, indicating the provider gave the member the information described in section (3)(g)(A-C); that the member had an opportunity to ask questions, obtain additional information and consult with the member's caseworker or representative; and that the member agreed to privately pay for the service by signing an agreement incorporating all the information described above. The provider must give a copy of the signed agreement to the member. A provider may not submit a claim for payment for covered services to the Division or to the member's MCE or third-party payer that is subject to the agreement.

- A provider may bill a member for services that are not covered by the Division or MCE. Before providing the non-covered service, the member must sign the provider-completed Agreement to Pay (OHP 3165) or a facsimile containing all the information and elements of the OHP 3165. The completed OHP 3165 or facsimile is valid only if the estimated fee does not change and the service is scheduled within 30 days of the member's signature. Providers must make a copy of the completed OHP 3165 or facsimile available to the Division or MCE upon request.

3.13 Coding

As a contracted provider, you play an important role in identifying conditions that impact members' health. Please code to the highest level of specificity and retain supporting documentation for each encounter. All applicable diagnosis codes should be included on the claim form including social determinants of health (SDoH) and external causes of morbidity. For more information on coding guidelines refer to your ICD-10-CM Official Guideline for Coding Manual.

3.14 Timely filing

Any provider billing SHP for services or supplies provided to our members must adhere to the following timelines for reimbursement consideration:

Samaritan Advantage Health Plans

- **Provider primary claims:** Providers must submit clean primary claims for medical, medical equipment and medical supplies per the time frame stated in your contract.
- **Provider secondary claims:** Providers must submit secondary claims within six calendar months of the date of the EOB for primary payment.
- **Claims corrections:** Corrected claims must be clearly marked in accordance with standard billing practices and must be received no more than 12 calendar months from the date of service on claim, unless a claim is reopened.

InterCommunity Health Network CCO

- **Provider primary claims:** Providers must submit clean primary claims for medical, medical equipment and medical supplies per the time frame stated in your contract.
- **Provider secondary claims:** Providers must submit secondary claims within six calendar months of the date of the EOB for primary payment.
- **Claims corrections:** Corrected claims must be clearly marked in accordance with standard billing practices and must be received no more than eighteen calendar months from tthe most recent process (EOB) date.

Samaritan Choice Plans

- **Provider primary claims:** Providers must submit clean primary claims for medical, medical equipment and medical supplies per the time frame stated in your contract.
- **Provider secondary claims:** Providers must submit secondary claims within six calendar months of the date of the EOB for primary payment.
- **Claims corrections:** Corrected claims must be clearly marked in accordance with standard billing practices and must be received no more than eighteen calendar months from the most recent process (EOB) date.

Samaritan Employer Group Plans

- **Provider primary claims:** Providers must submit clean primary claims for medical, medical equipment and medical supplies per the time frame stated in your contract.
- **Provider secondary claims:** Providers must submit secondary claims within six calendar months of the date of the EOB for primary payment.
- **Claims corrections:** Corrected claims must be clearly marked in accordance with standard billing practices and must be received no more than eighteen calendar months from the most recent process (EOB) date.

3.15 Reimbursement guidelines

SHP offers reimbursement guidelines on our provider website to assist you with many services you may provide. To view these guidelines please visit: providers.samhealthplans.org/Reimbursement.

Section 4: Care coordination

The Care Coordination Department oversees and monitors case management programs and services to coordinate, manage and evaluate the delivery of health care. The scope of the care coordination program includes all behavioral health, physical and oral health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities (SNF), home care services, outpatient care and office visits.

4.1 Utilization management

Prospective, concurrent and retrospective reviews are performed on a case by case basis to determine the appropriateness of care. Utilization Management (UM) decisions are made by qualified licensed health care professionals, who have the knowledge and skills to assess clinical information, evaluate working diagnoses and proposed treatment plans. Care coordination is supported by board certified UM provider reviewers, behavioral health providers and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed clinicians oversee UM decisions to ensure consistent and appropriate medical necessity determinations. Inter-rater reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria.

4.2 Utilization management disclaimer

Samaritan Health Plans providers, staff and contracted dental providers make decisions about the care and services that are provided based on a member's clinical needs, the appropriateness of care and service and the member's coverage. SHP does not make decisions regarding hiring, promoting or terminating its providers or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. SHP does not specifically reward, hire, promote or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. In order to maintain and improve the health of our members, all providers and health care professionals should be especially diligent in identifying any potential underutilization of care or services.

4.3 Authorizations

Care Coordination ensures accurate and timely processing of prior authorization related to durable medical equipment (DME), medical procedures and services including mental health and substance use disorder services. Utilization Management ensures that appropriate clinical information is obtained, documented and reviewed for all UM decisions. This process may include consulting with the requesting provider when appropriate. Authorizations may be submitted through the Authorization Wizard located on our online portal accessed through Provider Connect.

To submit any type of authorization other than a standard request, the following conditions must be met:

- **Expedited:** Submission must indicate that waiting for a decision within the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.
- **Retroactive:** Utilization Management follows state and federal regulations and contract language for review of retroactive authorization requests. As of May 1, 2019, retroactive requests will be reviewed for the extenuating circumstances listed below. If the exceptions are met, retroactive requests are processed according to the specific line of business authorization request policy. If the exceptions are not met the request will be denied. Retroactive authorization requests submitted by non-contracted providers and facilities will be accepted and processed in accordance with the line of business specific authorization request policy.
    - **Exceptions** – Retroactive authorization requests will be reviewed for medical necessity from contracted providers and facilities if:
        - The member indicated at the time of service that they were self-pay or no coverage was in place.
        - A natural disaster prevented the provider or facility from securing prior authorization or providing hospital admission notification.
        - Provider presents compelling evidence of attempt to obtain prior authorization in advance of the service. The evidence shall support the provider followed SHP policy and that the required information was entered correctly by the provider office into the appropriate system.
        - Member enrollment was entered retroactively in Facets and was not available at the time of service for the provider to obtain prior authorization from SHP.
        - Requested within seven calendar days of service for detoxification related to substance use, an initial outpatient mental health evaluation, day treatment, psychiatric residential treatment and subacute care.
        - Requested within seven calendar days of the dispense date for DME items provided at an office visit.
        - Requested within 30 calendar days for DME items that require a Certificate of Medical Necessity.

For more information regarding authorizations, please visit: providers.samhealthplans.org/Authorizations.

4.4 Clinical criteria

The plan's Evidence of Coverage (EOC) or plan document and federal and state guidelines are used to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines and company developed clinical standards are used to determine clinical and medical appropriateness of services.

The criteria are selected, developed, approved and overseen by the Care Coordination Department. Care Coordination will ensure clinical consistency and appropriateness of all criteria utilized by the Utilization Management team.

Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

The criteria utilized includes:

- MCG CareWebQ1 10.2 – assessment tools, review criteria and reporting.
- Centers for Medicaid and Medicare Services (CMS) - Coverage guidelines, a compendium of regulations, operation policy letters and manuals that are based on medical appropriateness criteria and clinical status of the patient to support decision-making: cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
- Samaritan Health Plans' medical coverage policies are based on local, regional and national practice standards, literature, research and consensus-based policy.
- The Oregon Health Plan (OHP), Oregon Administrative Rules (OAR) and Oregon Revised Statutes (ORS) provide guidance for interpreting IHN-CCO Medicaid benefits.
- Oregon Health Authority (OHA) Prioritized List of Health Care Services along with Guideline Notes as published on Oregon.gov/OHA/HSD/OHP/Pages/Prioritized-List.aspx.
- American Society of Addiction Medicine Criteria.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity, complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria.

The organization gives practitioners, with clinical expertise in the area being reviewed, the opportunity to advise or comment on the development or adoption of criteria.

4.5 Medical coverage policies

Medical coverage policies provide clinical criteria for decision-making and are developed when no appropriate external guidelines exist. Medical coverage policies do not determine covered benefits or whether a prior authorization is required. Medical coverage policies are made available to providers upon request.

4.6 Peer-to-peer consultation

Treating providers may request a peer-to-peer conversation with SHP Medical Review to discuss the reason(s) for a specific denial or adverse benefit determination of services/items. Peer-to-peer conversations may be requested via phone, email, fax or by visiting Samaritan Health Plans in-person.

4.7 Referrals for out-of-network services

Contracted providers are responsible for referring members to an in-network provider; however, members sometimes require care that is not available within our network of providers. When this occurs, the contracted provider may request a referral for the member to utilize an out-of-network provider or service. The request must indicate the reason for the medical necessity and the reason for the out-of-network referral request, e.g., no available contracted in-network provider, full provider panel or wait time to see contracted provider exceeds the medical necessity of the service. The contracted provider referring an IHN-CCO or Samaritan Advantage member for out-of-network services is also required to obtain all necessary prior authorizations as mandated by the plan.

For providers making referrals for SHP members, providers are responsible for only referring for services covered by CMS or Samaritan Health Plans.

Referrals made for IHN-CCO members, must be made to a Medicaid participating provider.

Out-of-state services

For Samaritan Advantage Health Plans and IHN-CCO, SHP may give prior authorization for non-emergency, medically appropriate, out-of-state services in accordance with state and federal requirements. This includes, but is not limited to, provider being enrolled as a current Oregon Medicaid and/or Medicare provider, services are not available in the state of Oregon and is considered a covered, medically appropriate service.

4.8 Care management services

Samaritan Health Plans care management services are offered as a supplemental resource to the provider care team to assist in serving members that have special health care needs, such as complex behavioral, medical and oral health conditions and social determinants of health barriers.

Care management services are designed to engage members, their families and caregivers to meet their care needs and goals and to promote continuity of care and effective use of resources. Care management services are voluntary and provided at no cost to the member.

Intensive Care Coordination (ICC)

ICC is a specialized care management program for members on IHN-CCO and who may have special health care needs or are part of a prioritized population. Examples include:

- Older adults: Individuals who are hard of hearing, deaf, blind or have other disabilities.
- Members with complex or high health care needs: Multiple or chronic conditions, SPMI or are receiving Medicaid-funded long-term care services and supports (LTSS).
- Children ages zero to five: Showing early signs of social/emotional or behavioral problems.
- Members with a serious emotional disorder (SED) diagnosis.
- Members in medication assisted treatment for SUD.
- Women who have been diagnosed with a high-risk pregnancy.
- Children with neonatal abstinence syndrome.
- Children in Child Welfare.
- IV drug users who have SUD and who need withdrawal management.

- Members who have HIV/AIDS.
- Members who have tuberculosis.
- Veterans and their families.
- Members at risk of first episode psychosis, and individuals within the intellectual and developmental disability (IDD) populations.

ICC services may include assistance to ensure timely access to providers; coordination of care to ensure consideration is given to unique needs; assistance to providers with coordination of services and discharge planning; coordination of community support such as social services.

Members are identified through direct referrals from contracted providers, community partners directly engaged with the member, referrals from utilization management, data analysis and member and member representatives.

Care management staff are assigned to support the member in developing an individualized care plan (ICP.) This may begin by completing a health assessment. The ICP is created by and for the member to positively impact health outcomes. The ICP addresses the member's clinical and social needs identified during the assessment or from the member and tracks the members identified goals and process to overcome barriers identified. The ICP is supported by the members interdisciplinary care team (ICT.) The team consists of internal and external health professionals and social supports working together to coordinate the member's care. The ICT coordinates care and develops a plan of care for high-needs members.

The member's primary care provider is responsible for developing a treatment plan for the member with the member's participation. The treatment plan should be in accordance with any applicable state quality assurance and utilization review standards.

Maternity case management

The maternity case management program's primary purpose is to optimize pregnancy outcomes, including reducing the incidence of low birth weight babies. Services are tailored to the individual member needs. The program is available to all pregnant IHN-CCO members and expands perinatal services to include management of health, economic, social and nutritional factors through the end of pregnancy and a two-month postpartum period. A multi-disciplinary care team consisting of a clinical care manager, behavioral health care manager and community health worker supports the member and her health care needs.

Complex case management

The complex case management (CCM) program is designed for members with chronic and/or complex medical/behavioral health conditions to promote independence, optimal health and continuity of care at the lowest cost appropriate to the member's needs. This may include members with new health catastrophic event or prolonged hospitalizations. Together, the nurse care manager and member establish an individualized plan that identifies specific health related goals and ways to address barriers to success. Interaction with a member's PCP and relevant specialists is also an important component of the care manager's role. Once a member has been identified and agrees to participate in complex case management program, the nurse care manager completes interventions such as the following:

- Completion of a telephonic assessment that includes core domains and medication review, pain assessment and depression screening.
- Members that have had a hospitalization are assessed for their understanding of their discharge instructions and follow-up care.
- Provider outreach for members in needs of additional coordination or medical intervention.
- Collaboration with multi-disciplinary team members such as social workers for community or behavioral health needs.
- Member education including mailed materials or shared resources for information or support.

Getting to know the Samaritan Health Plans' care team

Nurse clinical care managers: the clinical care manager is responsible for coordinating care in cooperation with the PCP and other providers; documenting care information and actions taken; developing an individualized care plan with the member; coordinating with member's care team and community resources; educating members as appropriate about member conditions, procedures and treatments and appropriate use of plan resources.

Behavioral health care managers: The behavioral health care manager provides screening, knowledge of criteria and clinical judgment to assess patient needs and assure that medically appropriate treatment is provided in a quality, cost-effective manner within the benefit plan of the member. Participates in care coordination and transition planning for members receiving mental health services and collaborates with community partners to identify member needs, support service delivery, and close gaps in members' care. Supports community efforts in establishing the Youth and Family System of Care and initiatives aimed at improving access to services and quality of care.

Community health workers (CHW): CHWs work in collaboration with the clinical care team and community partners. They assist members in accessing health care by connecting members to their PCP and helping them understand their health plan benefits, limits and guidelines. They also are integral in coordinating community supports and resources to reduce the barriers imposed by social determinants of health.

How to contact Care Coordination

Contact us by phone:

Monday through Friday, from 8 a.m. to 8 p.m.
541-768-5207 or toll free at **888-435-2396**.

Contact us by mail:

Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

Email the SHP Care Team

carecoordinationteam@samhealth.org

Section 5: Quality Management Program

Samaritan Health Plans' Quality Management (QM) program provides an overview of the structure and processes that enable the health plan to carry out its commitment to ongoing improvement in care and service and member health. Our objective is to give members compassionate and effective care that is easily accessible, safe, equitable and affordable. Quality improvement goals are focused on safety, preventive health, member and provider experience and delivering excellence in care and services that set community standards. The QM program assists the organization in achieving these goals.

Samaritan Health Plans and IHN-CCO board of directors govern the QM program. The program integrates network providers, social service agencies, community-based organizations, members, health plan departments and staff at all levels.

The program is comprised of four core components:

- Accreditation and standards.
- Health data analytics.
- Quality improvement.
- Patient safety.

SHP demonstrates commitment to quality through continuous improvement. Our program is ever-evolving in response to the changing needs of our members and the standards established by the provider community and regulatory and accrediting bodies. Providers can find information about our current Quality Management program at providers.samhealthplans.org/QM-Program.

5.1 Quality Improvement Workplan

The annual Quality Improvement (QI) Workplan governs the program structure and activities for the period of one calendar year. The QI Workplan includes quality improvement initiatives, targets, measures and metrics, activities and methods of performance tracking throughout the year to meet regulatory requirements for each line of business.

The QI Workplan:

- Reviews, evaluates and monitors internal and external data.
- Ties specific measurements to program goals and objectives.
- Outlines milestones, improvement targets and measurements.
- Interventions are revised based on analysis findings.

5.2 Quality Management Council (QMC)

Our Quality Management Council (QMC) is the responsible entity for the oversight and management of all quality-related activities. The QMC is chaired by the chief medical officer and is comprised of community partners and network clinicians representing primary care, behavioral health, oral health and specialties. SHP functional area directors and health plan staff participate as required. The Quality Management Council meets at least quarterly and provides guidance for the QM Program. It oversees quality monitoring and improvement activities and evaluates the effectiveness of key services provided to members, providers and regulatory agencies.

5.3 Quality improvement projects

The Quality Management program includes numerous quality improvement projects. The Chronic Care Improvement Program (CCIP) for Medicare Advantage members ensures members with chronic conditions are effectively managed. The performance

improvement projects (PIP) for IHN-CCO members focus on improving care and health outcomes. We encourage providers to review the list of current quality improvement projects at providers.samhealthplans.org/QM-Program.

5.4 Evidence-based clinical practice guidelines

SHP evaluates practice guidelines, standards and policies for dental care, medical and behavioral health practice to ensure alignment with evidence-based practice, community standards and relevant law. The QMC reviews, adopts and disseminates evidence-based clinical practice guidelines. Clinical practice guidelines (CPGs) are reviewed and updated at least every two years or as needed to reflect current standards and scientific knowledge. Clinical practice guidelines encompass acute, chronic and preventive care relevant to the SHP membership. CPGs are available to community clinicians, network providers and members. To evaluate delivery of services in accordance with approved guidelines, annual performance measurements are analyzed using claims data, lab data, and electronic health record (EHR) data. View our current clinical practice guidelines at samhealthplans.org/Clinical-Guidelines.

5.5 HEDIS/HOS/CAHPS

Healthcare Effectiveness Data and Information Set (HEDIS) performance measures allow SHP to benchmark and compare performance with similar health plans across the nation. HEDIS measures cover 75 aspects of care and span the following six domains of care:

- Access/availability of care.
- Effectiveness of care.
- Experience of care.
- Health plan descriptive information.
- Measures reported using Electronic Clinical Data Systems (ECDS).
- Utilization and risk adjusted utilization.

HEDIS measures are calculated by the National Committee for Quality Assurance (NCQA) certified software using data from claims, supplemental data collected from electronic health records and/or manual chart review. HEDIS is performed and reported annually as required by Centers for Medicare and Medicaid Services (CMS). HEDIS results are annually audited by certified auditors using a rigorous process designed by NCQA, including an audit review specifically focused on information and reporting systems. Results are used to target specific opportunities for improvement.

The Health Outcomes Survey (HOS) is used to gather health status data from our members. HOS is administered to a cohort of Medicare Advantage members each year. The same cohort of members is surveyed again two years later. Those two studies are compared to determine if the care received is keeping the member as healthy as possible. Results from this survey are captured in the health plan's Medicare Stars rating.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that focuses on how members experienced or perceived key aspects of their care. The CAHPS survey is conducted in the spring of each year (for the previous reporting year). This information is particularly useful in identifying opportunities for improvement in delivering health care and services to our members. CAHPS survey results are a key part of the Medicare Star rating and CCO state metrics.

6.1 Samaritan Advantage Health Plans

Special circumstances allow a provider to appeal for a medical, pharmacy or durable medical equipment (DME) authorization or payment denial on behalf of a patient. SHP follows strict rules and regulations set forth by Medicaid, Medicare and the federal government. These rules and regulations are subject to change.

For further information about appeal rights, time frames to submit appeals and to download appeals forms for each plan, please visit: providers.samhealthplans.org/Appeals.

Urgent situations: Pre-service denials

Medical appeal

Any treating provider or provider office staff acting on behalf of their patient, or staff of provider's office acting on provider's behalf (e.g., request is on provider's letterhead), can appeal a pre-service denial on their patient's behalf by submitting a verbal or written appeal request directly to SAHP **without** filling out a CMS 1696 form. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function.

Pharmacy appeal

Any provider/prescriber acting on behalf of their patient or staff of provider's office acting on provider's behalf (e.g., request is on provider's letterhead) can appeal a pre-service denial on their patient's behalf by submitting a verbal or written appeal request directly to SAHP **without** filling out a CMS 1696 form. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health or life or ability to regain maximum function.

Standard pre-service denials

Medical appeal

Any treating provider acting on behalf of their patient or staff of provider's office acting on provider's behalf (e.g., request is on provider's letterhead) can appeal on the patient's behalf **without** filling out a CMS-1696 form. This applies when the patient has not received the service. Medicare assumes the treating provider has documented a conversation with the patient regarding the intent to appeal on their behalf.

Pharmacy appeal

Any provider/prescriber acting on behalf of their patient or staff of provider's/prescriber's office acting on provider's/prescriber's behalf (e.g., request is on provider's/prescriber's letterhead) can appeal on the patient's behalf **without** filling out a CMS-1696 form. This applies when the patient has not received the medication. Medicare assumes the provider/prescriber has documented a conversation with the patient regarding the intent to appeal on their behalf.

To submit a verbal appeal request, please call SHP Customer Service at **541-768-5207**, or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m.

Payment denials

A contracted provider does not have appeal rights. If a contracted provider wants to appeal on the patient's behalf, they may do so only after completing an Appointment of Representative form. With your appeal, please include Medicare's **CMS-1696 Form** (cms.gov/cms1696-appointment-representative), a legal court appointed representative document or the equivalent. Both the patient or legal representative and the contracted provider must complete their applicable sections of the form before the appeal will be processed.

- The member and the provider need to complete, print and sign the Medicare Appointment of Representative form, **CMS- 1696 Form** and include this with your appeal. Send the form, the appeal requests and any supporting documentation to SHP to the attention of the Appeal Team.
- Any non-contracted provider can appeal a denied payment but only after completing a **Waiver of Liability** (providers.samhealthplans.org/Waiver-of-Liability). Send the waiver and any supporting documentation to SHP to the attention of the Appeal Team.

Please submit your completed form(s), appeal letter and supporting documents through one of the following ways:

Fax: 541-768-9765

Email: shpoappealsteam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

Time frame to appeal

SAHP	Time frame to request appeal	Appeal time
Medical	60 days from the initial decision	Expedited = 72 hours Standard pre-service = 30 calendar days Standard post-service = 60 calendar days
Pharmacy	60 days from the initial decision	Expedited = 72 hours Standard = Seven (7) calendar days
Extension, when applicable for processing an appeal.	–	Additional 14 calendar days (pre-service ONLY)

6.2 InterCommunity Health Network Coordinated Care Organization

IHN-CCO, subcontractors and participating providers may not:

- Discourage a member from using any aspect of the grievance, appeal or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal.
- Encourage the withdrawal of a grievance, appeal or hearing request already filed.
- Use the filing or resolution of a grievance, appeal or hearing request as a reason to retaliate against a member.

Urgent situations

A member or a member's authorized representative and/or provider can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to IHN-CCO **with** member's (or member's authorized representative) written consent. To submit a verbal request, please call IHN-CCO Customer Service at **541-768-5207**, or **888-435-2396**, Monday through Friday, from 8 a.m. to 6 p.m. Please send written requests to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

IHN-CCO may not take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.

Standard pre-service and payment denials

A member or a member's authorized representative and/or provider can appeal on the patient's behalf with written consent from the patient or patient's authorized representative. A copy of the written consent signed and dated by the patient or their authorized representative, must be received by IHN-CCO before the appeal will be processed.

If a member or a member's authorized representative and/or provider needs help with filing an appeal, please contact IHN-CCO Customer Service at **541-768-5207**, or **888-435-2396**, Monday through Friday, from 8 a.m. to 6 p.m. (TTY 800-735-2900). Please submit your completed appeal letter with the member's (or member's authorized representative) written consent by one of the following:

Fax: 541-768-9765

Email: shpoappealsteam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

State fair hearing:

A hearing cannot be requested without first filing an appeal with IHN-CCO. A member or a member's authorized representative and/or provider may have access to appeal for IHN-CCO's action by requesting a contested case hearing with a written consent from the member's or member's authorized representative. The hearing can be requested through the Office of Administrative Hearings no later than 120 days from the date of the notice of appeal resolution. The hearing request form MSC 0443 can be found on the Oregon Health Authority website at Oregon.gov.

Duration of continued benefits:

Continuation of benefits pending appeal resolution:

If, at the member's request, IHN-CCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The member withdrawals the appeal.
b. IHN-CCO issues an appeal resolution.
c. The original authorization expires or the authorization service limits are met.

Continuation of benefits pending Contested Case Hearing resolution

If, at the member's request, IHN-CCO continues or reinstates the member's benefits while the Contested Case Hearing is pending, the benefits must be continued until one of the following occurs:

a. The member does not request a Contested Case Hearing within 10 days from when IHN-CCO mails the Notice of Appeal Resolution letter.
b. The member withdraws their request for Contested Case Hearing.
c. A final Contested Case Hearing decision adverse to the member is issued.
d. The original authorization expires or authorization service limits are met.

Time frame to appeal

IHN-CCO	Time frame to request appeal	Appeal time
Medical	60 days from the initial decision	Expedited = 72 hours Standard pre-service = 16 calendar days Standard post-service = 16 calendar days
Pharmacy	60 days from the initial decision	Expedited = 72 hours Standard = 16 calendar days
Extension, when applicable for processing an appeal.	–	Additional 14 calendar days

Grievances

A member or a member's authorized representative and/or provider can file a grievance to IHN-CCO and/or directly with OHA on behalf of the member with a written consent from the member or member's authorized representative.

To submit a grievance, a member or a member's authorized representative and/or provider can contact IHN-CCO Customer Service at **541-768-4550** or **800-832-4580**, Monday through Friday, from 8 a.m. to 6 p.m. **(TTY 800-735-2900)**. You may also submit

your grievance to IHN-CCO Grievance Team at: shpogrvcteam@samhealth.org and/or to Oregon Health Plan Client Services listed below.

If a member or a member's authorized representative and/or provider is not happy with outcome/resolution of a grievance, please submit your grievance to: The Oregon Health Plan by calling, mailing or online:

Mail: Oregon Health Plan Client Services
PO Box 14520
Salem, OR 97309

Call: Client Services at **800-273-0557**

Online: apps.state.or.us/forms/served/he3001.pdf

Time frame for grievances

Filing a grievance/complaint to IHN-CCO	**No time frame limit**
IHN-CCO acknowledging a grievance/complaint was received	Members and/or their authorized representative are notified in writing within five (5) business days that SHP received their grievance/complaint.
IHN-CCO standard decision time frame	**Five (5) business days**
Extension time frame (from the extension date)	**25 calendar days** *An extension may only be taken when requested by the member or if SHP justifies a need for additional information and documents how the delay is in the best interest of the member.*

6.3 Samaritan Choice Plans

Urgent situations

Any provider can appeal, **without written consent from the member**, a pre-service denial on their patient's behalf by submitting a verbal or written request directly to Samaritan Choice Plans (SCP). To submit a verbal request, please call SCP Customer Service at **541-768-5207**, or **888-435-2396**, Monday through Friday, from 8 a.m. to 6 p.m. Send written requests to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

Standard pre-service and payment denials

A provider can appeal on the patient's behalf with written permission from the patient or their authorized representative. A copy of the written permission signed and dated by the patient or authorized representative, must be received by SCP before the appeal will be processed.

Please submit your completed appeal letter with the member's (or member's authorized representative) written consent to:

Fax: **541-768-9765**

Email: shpoappealsteam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

Time frame to appeal

SCP	Time frame to request appeal	Appeal time
Medical	180 days from the initial decision	Expedited = 72 hours Standard pre-service = 30 calendar days Standard post-service = 60 calendar days
Pharmacy	180 days from the initial decision	Expedited = 72 hours Standard = 30 calendar days

6.4 Samaritan Employer Group Plans

Urgent situations

Any provider can appeal, **without written consent from the member**, a pre-service denial on their patient's behalf by submitting a verbal or written request directly to Employer Group Plans. To submit a verbal request, **without** written consent from the member, please call **541-768-5207**, or **888-435-2396**, Monday through Friday, from 8 a.m. to 6 p.m. Send written requests to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

Standard pre-service and payment denials

A provider can appeal on the patient's behalf with written permission from the patient or their authorized representative. A copy of the written permission signed and dated by the patient or authorized representative, must be received by SHP before the provider's appeal will be processed.

Please submit your completed appeal letter with the member's (or member's authorized representative) written consent to:

Fax: 541-768-9765

Email: shpoappealsteam@samhealth.org

Mail to: Samaritan Health Plans
Attn: Appeals Team
PO Box 1310
Corvallis, OR 97339

Time frame to appeal

Employer Group	Time frame to request appeal	Appeal time
Medical	180 days from the initial decision	Expedited = three (3) days Standard pre-service = 30 calendar days Standard post-service = 30 calendar days
Pharmacy	180 days from the initial decision	Expedited = three (3) days Standard = 30 calendar days

Section 7: Pharmacy

7.1 Formulary

SHP maintains a formulary or list of prescription medications that are approved for use and/or coverage by the plan and dispensed through participating pharmacies to covered members. Drug formularies are developed and maintained with direction from the SHP Pharmacy and Therapeutics (P&T) Committee and specific to the member's insurance plan. SHP may modify the drug formulary to ensure that the formulary includes the most current evidence-based information. Formularies are located on the SHP provider website at providers.samhealthplans.org/Pharmacy.

SHP contracts with a pharmacy benefit manager (PBM) for administration of the outpatient prescription benefit. This does not apply to injectable medications administered in an inpatient setting, i.e. skilled nursing facilities (SNF), group homes, hospitals or skilled care. Exceptions may apply for Samaritan Advantage Health Plans.

Generic medications are strongly recommended unless a therapeutically equivalent generic is not available or the generic product is contraindicated. Prescriptions are allowed to be dispensed for the length of time specified in the chart below. Medications have a 75% utilization on most drugs and for controlled substances a 90% utilization at retail or 80% through mail order required prior to refill.

Plan	Allowed Dispensing Amounts
Samaritan Advantage	Non-specialty: 90 days Specialty and drugs marked NDS on formulary: 34 days **Controlled substances:** New to therapy: 7 days (max 90 MME) Experienced: 30 days (max 200 MME)
Commercial plans	Non-specialty: 90 days Specialty: 34 days **Controlled substances:** New to therapy: 7 days (max 50 MME) Experienced: 30 days (max 90 MME) **Contraceptives:** Choice Plan: 180 days Large and Small Group Plans: 1 year
InterCommunity Health Plan	34 days **Controlled substances:** New to therapy: 7 days (max 50 MME) Experienced: 30 days (max 90 MME) * Certain formulary and generic oral maintenance medications to treat diabetes, hypertension, cholesterol and all contraceptives are allowed to be filled for 90 days.

Some prescriptions require pre-authorization (this may not apply when administered in an inpatient hospital or SNF setting). Most medications that require preauthorization have specific criteria and approval periods documented for providers to reference prior to submitting a request for coverage. This documentation is located with the formularies at providers.samhealthplans.org/Pharmacy.

7.2 Non-formulary drugs

If it is medically necessary for a member to have a drug that is not on the member's insurance plan formulary, a formulary exception request may be submitted. A provider may submit the formulary exception request using the form available on our website or prescribers can submit a request electronically at providerportal.surescripts.net/ProviderPortal/login. For Medicare plans a provider, member or member's representative may submit a request for a medication exception by calling SHP Pharmacy Services. The exception request form can be found at providers.samhealthplans.org/Medications.

7.3 Specialty drugs

Specialty drugs are high-cost prescription medications and biologicals used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs may require special handling and administration. Specialty drugs may be covered through either the medical or prescription drug insurance. Most specialty drugs must be provided by a specialty pharmacy. Samaritan Health Services Specialty Pharmacy can deliver medications to your patients' home and will partner with their health care team to ensure medications are being refilled and well tolerated. For more information please contact Samaritan Health Services Specialty Pharmacy at **541-768-1299**, weekdays, 8 a.m. to 4:30 p.m. Please consult the formularies on our website for more information about specialty medications and biologicals and insurance requirements.

7.4 Quantity limits

For certain drugs, there are restrictions on the amount or quantity of medication that the plan will cover over a specific time period. These requirements are developed using FDA and manufacturer dosing guidelines, current evidence-based best practices and the latest pharmaceutical compendia. These limitations are reviewed and approved by the SHP P&T Committee. Please consult the formularies on our website for more information about these requirements and limits. For all insurance plans a provider can submit a formulary exception request by using the form available on our website or prescribers can submit a request electronically at providerportal.surescripts.net/ProviderPortal/login. For Medicare plans a provider, member or member's representative can submit a medication exception request by calling SHP Pharmacy Services.

7.5 Step therapy

Step therapy is used for medications that are not first line treatment and require one or more prerequisite medications before prescribing. SHP enforces step therapy for medications as determined by the SHP P&T Committee. SHP requires the use of a less expensive medication when there is a cost difference between therapeutically equivalent medications. SHP approves the next step in therapy when members are unable to tolerate the first line medications or have adverse outcomes when taking the first line medications. The SHP claims system may automatically bypass step therapy criteria if it recognizes claims in the members history

meeting the required criteria. When a claim is adjudicated, the claims payment system looks for any instance of a first line medication and if found, will automatically approve the claim. If, however, the first line medication is not found, the claims payment system denies the claim and gives a rejection notice to follow step therapy. For all plans a provider can submit the formulary exception request using the form available on our website or prescribers can submit a request electronically at providerportal.surescripts.net/ProviderPortal/login. For Medicare plans a provider, member or member's representative can submit a medication exception by calling SHP Pharmacy Services.

7.6 Tier lowering

Prescription costs can often be a barrier for many patients. If a patient's drug cost is too high, perhaps there is a different drug in a lower cost sharing tier that might work just as well for the patient. Using the plan formularies listed on our website, you can find alternatives that may be more cost effective for your patients. If there are no alternatives on a lower tier, you can ask the plan to make an exception to the cost sharing tier. If the request qualifies for a tier exception and is approved by the plan, the patient may pay less for their medication. The exception request form can be found at providers.samhealthplans.org/Medications or prescribers can submit a request electronically at providerportal.surescripts.net/ProviderPortal/login.

7.7 Electronic prior authorization

SHP has implemented electronic prior authorization services for our providers with SureScripts. This is a free service for those who have access through their integrated EHR or through the SureScripts provider portal. SureScripts ePA is designed to give clinicians and staff more time to focus on quality patient care without the administrative burden of manual prior authorizations. This saves users valuable time by eliminating the forms, faxes and phone calls associated with submitting prior authorizations. To sign up and get started, please visit providerportal.surescripts.net/ProviderPortal/login.

7.8 Adherence

Refilling prescriptions can be a major barrier to medication adherence for patients with chronic medical conditions. By prescribing 90-day supplies for maintenance medications, you can help your patients increase adherence by minimizing multiple pharmacy visits. In addition, patients receiving 90-day supplies of chronic medications through the mail have significantly higher adherence rates compared to buying 30-day supplies at their local pharmacy. Please consider writing 90-day supply prescriptions for maintenance medications for your patients.

7.9 Required Medicaid Enrollment

Federal Medicaid program integrity regulations — 42 CFR §455.410(b), 42 CFR §455.440 and the Medicaid Provider Enrollment Compendium, Section 1.3 — require all providers who write prescriptions for Medicaid members to be enrolled as a Medicaid provider in the member's state. If they are not enrolled, Medicaid cannot cover the prescription. This is true even if the provider is enrolled as a Medicaid provider in a different state. This rule also applies to all resident providers with prescribing authority. In compliance with these regulations and beginning Jan. 31, 2022, IHN CCO will stop covering prescriptions written by providers who do not have a current Oregon Medicaid ID.

Section 8: Providers

8.1 Eligible providers

SHP considers the following list of physicians and practitioners eligible to be considered as participating providers. Eligible providers include, but are not limited to:

Providers and practitioners

- Doctor of medicine.
- Doctor of osteopathy.
- Oral surgeon, doctor of dental medicine.*
- Podiatrist.

Allied and behavioral health care providers

- Audiologist.
- Behavior analyst, board certified.
- Certified nurse midwife.
- Certified registered nurse anesthetist.
- Clinical nurse specialist.
- Genetic counselor (when services are a covered benefit of the member's plan).
- Hearing aid specialist.
- Licensed clinical social worker.
- Licensed dietitian.
- Licensed marriage and family therapist.
- Licensed professional counselor.
- Nurse practitioner.
- Occupational therapist.
- Optometrist.
- Physician assistant.
- Physical therapist.
- Psychologist.
- Psychologist associate.
- Speech/language therapist.

Alternative care providers

- Acupuncturist.
- Chiropractor.
- Licensed massage therapist.
- Naturopath.

Organizational providers

- Hospital.
- Home health agency.
- Hospice.
- Skilled nursing facility.
- Sleep study lab.
- Freestanding ambulatory surgery center.
- Behavioral health facility.
- Birthing center.
- Home infusion.
- Clinical laboratory.
- Comprehensive outpatient rehabilitation facility.
- End-stage renal disease dialysis center.
- Portable X-ray supplier.
- Rural health clinic.
- Federally qualified health center.
- Independent diagnostic testing facility.
- Durable medical equipment supplier.
- Public health center.

* *Credentialing is required only for maxillofacial surgeons providing care under medical benefits.*

SHP does not require credentialing for some types of practitioners, such as practitioners who practice exclusively within the inpatient setting and who provide care for organization members only as a result of being directed to the hospital or other inpatient setting. Some examples of practitioners who may not need to be additionally credentialed by SHP include, but are not limited to:

- Pathologists.
- Radiologists.
- Anesthesiologists.
- Neonatologists.
- Emergency room physicians.
- Behavioral health care practitioners.
- Hospitalists.
- Non-licensed providers (as required by state or federal statute).

Note: Hospitalists or others who occasionally work in the private clinic setting must complete the credentialing process.

8.2 Primary care providers

When a provider is designated as a primary care provider (PCP) under the InterCommunity Health Network CCO or Samaritan Advantage Health Plans, they agree to provide and coordinate health care services for those assigned panel of members. The PCP will refer members to in-network provider specialists and is also responsible for reviewing treatment rendered by specialists or other servicing providers.

8.3 Locum tenens

A locum tenens arrangement is made when a participating provider must leave their practice temporarily due to illness, vacation or leave of absence. Locum tenens is a temporary replacement for that provider, for a specified amount of time, not to exceed 60 days. If the locum tenens provider will be covering for more than 60 days, the locum tenens provider is required to be credentialed.

8.4 Traditional health workers

A traditional health worker (THW) is a community health worker, certified recovery mentor, peer wellness specialist, personal health navigator, peer support specialist or birth doula. All THW provide resources, education and work with members to promote healthy behaviors and link members to resources in their community.

THWs can help members with scheduling appointments, finding rides to appointments, accessing food, finding childcare and getting screening tests. THWs are part of the community support services available in Benton, Lincoln and Linn counties and prior approval or referral is not required for members to utilize their services.

Specialty types of THWs and the services they provide:

Birth doula: Provides support to members and their family during pregnancy, childbirth and after giving birth.

Community health worker: Helps members adopt healthy behaviors and navigate the health care system.

Certified recovery mentor: Focuses on supporting the member through recovery from addiction and have personal experience with addiction.

Personal health navigator: Provides information, assistance, tools and support to help members make the best health care decisions.

Peer support specialist: Focuses on supporting members through recovery from addiction and/or mental health conditions.

Peer wellness specialist: Works as part of the member-driven care team. This team combines behavioral health and primary care needs to assist and advocate for the member in improving their well-being.

Please contact our traditional health worker liaison to learn more about these types of providers and how they can help. Locally, call **541-768-4550** or toll free **800-832-4580 (TTY 800-735-2900)**.

8.5 Networks

SHP is always looking for ways to best meet the needs of our members. We know members benefit from the convenience of a large network of providers, which is why we offer access to the following networks:

Samaritan provider network

Samaritan Health Plans' network covers Benton, Lincoln and Linn counties and many providers and facilities throughout the state of Oregon.

The Samaritan provider network is available to all lines of business we serve. To view our directory of contracted providers please visit samhealthplans.org.

First Choice Health Network

First Choice Health Network (FCHN) consists of primary care, specialty care and facilities throughout Alaska, Idaho, Montana, North Dakota, Oregon, South Dakota, Washington and Wyoming. This network is accessible to our Samaritan Choice Plans and Samaritan Employer Group Plans members at FCHN.com.

First Health Network

First Health Network (FHN) offers additional U.S. coverage outside of the First Choice Health Network. This network is accessible to our Samaritan Choice Plans and Samaritan Employer Group Plans' members and can be found at providers.samhealthplans.org/Refer-For-Care.

Reliant Behavioral Health

Reliant Behavioral Health (RBH) is utilized to administer behavioral health services to our Samaritan Advantage Health Plans, Samaritan Choice Plans and Samaritan Employer Group Plans members. If you are a mental health provider and want to contract with these lines of business, please email a letter of interest to providerrelations@reliantbh.com.

CHP Group

CHP Group is a network of alternative and holistic care providers consisting of naturopathic care, chiropractic services, acupuncture treatments and massage therapy. SHP utilizes this network for services provided to our Samaritan Employer Group Plans members. View participating providers at chpgroup.com/find-a-provider/#practop.

8.6 Contracting

SHP has a dedicated department to answer your contracting questions. The Network Strategy and Contracting Department is available to assist you with contract negotiations, contract concerns and clarifications.

If you are interested in contracting with one or all of our lines of business, complete the Letter of Interest (LOI) located on the provider section of the SHP website at providers.samhealthplans.org/Provider-Credentialing.

By joining the Samaritan Health Plans network of providers, we will provide you with tools and resources to support you and ensure that we are all able to work effectively and efficiently, together. In-network providers can access and benefit from:

- Direct support for all contracting, claims and operational inquiries.
- Provider trainings and educational materials.
- The provider manual, which includes our policies and procedures.
- Provider directories listing all contracted providers.
- Quality programs and initiatives.

8.7 Credentialing

SHP's credentialing standards follow the guidelines of the National Committee on Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS). The credentialing process includes meticulous verification of the education, experience, judgment, competence and licensure of all health care providers.

SHP believes the emphasis on credentialing further demonstrates a commitment to qualified health care physicians and providers performing services our members require.

SHP requires all providers rendering services to be individually credentialed before they can be considered an in-network provider under the provider contract.

SHP does not allow "incident to" billing for providers that are eligible for credentialing and practicing under their scope of license.

SHP does not require credentialing for some types of practitioners, such as practitioners who practice exclusively within the inpatient setting and who provide care for organization members only as a result of being directed to the hospital or other inpatient setting. Some examples of practitioners who may not need to be additionally credentialed by Samaritan Health Plans include, but are not limited to:

- Pathologists.
- Radiologists.
- Anesthesiologists.
- Neonatologists.
- Emergency room physicians.
- Behavioral health care practitioners.
- Hospitalists.
- Non-licensed providers (as required by state or federal statute).

Note: Hospitalists or others who occasionally work in the private clinic setting must complete the credentialing process.

Initial credentialing process

The initial credentialing process at SHP involves three basic phases: application, review and decision. The requirements and details of each phase are described below. This process can take up to 90 days upon receipt of a complete application. Dental care organizations perform credentialing for dental providers. Refer to DCOs for applications and processing.

Phase 1: Application

Providers are required to submit an application and complete our credentialing process prior to being considered an in-network provider with SHP. Individual practitioners must submit the Oregon Practitioner Credentialing Application (OPCA) to begin the credentialing process. Organizational providers must complete the Organizational Provider Credentialing Application. Please note that any new practitioners in your group will be considered out-of-network until the credentialing process has been completed and the provider has been approved by the Samaritan Health Services Credentialing Committee.

Once the credentialing application has been completed, a copy of the application can be used in the future, provided no information has changed in the interim; however, signatures and attestation statements must be no more than 180 days old at the time of the credentialing decision.

Provider credentialing

Contracting is contingent on credentialing approval. SHP follows the Centers for Medicare and Medicaid (CMS) and the National Committee for Quality Assurance (NCQA) requirements for credentialing providers. In order to credential practitioners and other health care professionals, SHP requires:

- Oregon Practitioner Credentialing Application (OPCA).
- Completed and signed attestation and release form.
- Completed and signed Attachment A (mark N/A if not applicable, sign and date).
- Copy of current, unrestricted Oregon state license and/or registration.
- Current, valid DEA certificate(s) (if applicable).
- Copy of your current liability certificate showing the coverage dates and limits of liability.
- List of all medical malpractice carriers for the past five years, including carrier name, address, policy number, limits and any claims history information.
- Copy of board certificate(s) – preferred.
- Copy of PA practice description and Oregon Medical Board (OMB) supervising physician approval letter (if applicable).
- Copies of medical school diploma and/or completion certificates from medical training – preferred.
- Copies of internship and residency completion certificates – preferred.
- A minimum of five years of relevant work history.
- Hospital privileges (if applicable).

PLEASE NOTE: Your credentialing application will only be processed once all required documents are received and your application is considered complete. You will be notified by Samaritan Health Services (SHS) once this process is complete.

Exceptions: Providers are not required to be credentialed by SHP if they practice exclusively in an inpatient setting and provide care to the plan's members as a result of the member being directed to the hospital or other inpatient setting.

Review our credentialing requirements at providers.samhealthplans.org/Provider-Credentialing.

Facility credentialing

The following is a listing of information Samaritan Health Plans needs in order to credential facilities:

- Organization provider credentialing. Application (OPCA) – required.
- W9 form.
- DEA – if applicable.
- Copy of Medicare and/or Medicaid certification – if applicable.
- Copy of current, unrestricted state license, certification and/or registrations specifically required to operate as a healthcare provider – required.
- Copy of your current liability certificate – required.
- Copy of certification from an accredited agency or current CMS/state survey, including corrective action plans for identified deficiencies – required.
- Appropriate policies regarding the use of restraints and/or seclusion.

For more information, contact Samaritan Health Plans' Provider Relations at **541-768-5207**, Monday through Friday, from 8 a.m. to 8 p.m. or at SHPprovider@samhealth.org

Phase 2: Review

The Samaritan Health Services Credentialing Department is responsible for processing credentialing requests for providers requesting to participate in our provider network. The Samaritan Health Services Credentialing Committee evaluates provider candidates for credentialing and makes the final determination on credentialing requests. Credentialing criteria is based on standards set by the National Committee for Quality Assurance (NCQA), and the credentialing committee is responsible for applying those criteria in a fair and impartial manner.

The credentialing committee has the right to make the final determination about which providers participate within the network. If unfavorable information about a specific provider is discovered during the credentialing process, e.g., professional liability settlements, sanctions, erroneous information or other adverse information, the committee may choose not to credential the provider.

Phase 3: Decision

Upon the credentialing committee's approval, the provider will be notified in writing of their acceptance. The provider will then be recredentialed at least every three years.

Providers who are not approved or do not meet the criteria set forth by the credentialing committee will be notified in writing via certified mail.

If the credentialing committee does not approve the provider, the provider may be considered nonparticipating or out-of-network, subject to out-of-network authorization requirements and claims processing. There may be reasons (e.g., fraud, inappropriate billing practices, other violations of SHS rules or legal boundaries)

whereby claims payments may not be approved. After credentialing is complete, the provider's in-network effective date will be the first of the month in which credentialing is approved by the Samaritan Health Services Credentialing Department, as long as there is a current contract on file for the individual provider or the group that employs that provider.

Adequate professional liability coverage

SHP requires physicians and providers to procure and maintain appropriate general and professional liability insurance coverage. The minimum acceptable professional liability insurance includes a one million per claim/three million aggregate amount ($1,000,000/$3,000,000) and is required for all practitioners and organizational providers eligible for credentialing noted in the beginning of the credentialing section.

Recredentialing

The recredentialing process will be conducted for each in-network provider no less frequently than every three years, or according to applicable standards at the time. A notice that recredentialing is due will be sent to the provider approximately four to six months prior to the credentialing period expiration date.

Failure to return the information by the due date will result in termination from the SHP network and will affect claims payment. If the provider is reinstated after such termination, the provider will be required to complete the full credentialing process, as deemed necessary by NCQA and CMS.

At a minimum, the recredentialing process will include verification or review of items noted in the Initial Credentialing Process section, including quality improvement activities.

The decision process is the same for recredentialing as for initial credentialing (see Phase 3: Decision in the Initial Credentialing Process section). Providers who are approved for a recredentialing period of less than three years will be notified in writing. Providers who are denied continued participation will be notified in writing via certified mail and are awarded appeal rights. Providers are notified of these rights and the process to request an appeal at the time of credentialing termination. Appeal rights are not granted for providers terminated for administrative reasons, such as loss of an active license, failure to recredential, and so on.

Practitioner rights

SHP practitioners are afforded certain rights during the credentialing and recredentialing process. These rights include, but are not limited to:

- The right to review information submitted to support the credentialing application, including information received from outside sources such as malpractice insurance carriers and state licensing boards. This right does not include the ability to review references, recommendations, or other peer-review protected information.
- The right to correct erroneous information when information submitted on the application varies substantially from information obtained during the credentialing process. The Credentialing Department will notify the provider when such information is identified, with the appropriate time frames and format to make

necessary corrections. SHS is not required to reveal the source of the information verified, if federal or state law prohibits disclosure.

- The right to be informed of the status of your credentialing and recredentialing applications, upon reasonable request. The Credentialing Department may provide projected time lines for completion, including possible delays, information pending or missing, and substantial variations in formation verified during the credentialing process.

8.8 Update your information

Demographic information

For members to have the most accurate contact information in the provider directories, we require providers to submit all demographic changes to SHP within 30 days. Submissions can be completed at providers.samhealthplans.org/Update-Your-Info.

Adding or terminating a provider

If you are an established contracted group, complete the "update your information" form online to begin the process of adding or terminating a provider from your group. Credentialing of a new provider can take up to 90 days so timely notification is essential. providers.samhealthplans.org/Update-Your-Info.

8.9 Accessibility

Access to care

IHN-CCO providers must adhere to the timeliness of access to care standards related to primary care, emergent/urgent care and behavioral health care.

Monitoring of adherence will be conducted by the Network Strategy and Contracting Department on an annual basis via telephonic surveys, on-site visits or member complaints. Non-compliance will be reviewed by the Network Strategy and Contracting Department to identify opportunities for improvement and/or corrective action if necessary.

Primary care providers

- Preventative primary care appointments (annual visits, pediatric/adult immunizations and annual GYN exams) – within four weeks.
- Urgent care appointments (high fever, vomiting etc.) – within 72 hours or as indicated in the initial screening for urgent care.
- Emergency care – same day.
- After-hours care – provider offices must maintain 24-hour phone availability (call share, answering machine or answering service) advising members on access options.

Behavioral health services

- All InterCommunity Health Network (IHN-CCO) members will have direct access to behavioral health services by contacting their primary care provider office or by going to the emergency department.

Specialty care services

- Urgent care appointments – Within 72 hours or as indicated in the initial screening for urgent care.
- After-hours care – provider offices must maintain 24-hour phone availability (call share, answering machine or answering service) advising members on access options.

Primary care dental services

- Routine care – within eight weeks.
- Urgent care – within one week or as indicated in initial exam in accordance with OAR 410-123-1060.
- Emergency care – seen or treated within 24 hours.

On-call policy

Participating primary care providers (PCP) and primary care dentists agree to accept new Samaritan Advantage Health Plans (SAHP) or InterCommunity Health Network (IHN-CCO) members unless the practice has closed to new patients. Participating providers agree to provide 24-hour, seven-day-a-week coverage for IHN-CCO and SAHP's members in a culturally competent manner and in a manner consistent with professionally recognized standards of health care. The provider or his/her designated covering provider will be available on a 24-hour basis to provide care or to direct members to the setting most appropriate for treatment.

Hours of operation

Participating health providers shall make the services they provide including: specialty, pharmacy, hospital, vision and ancillary services as accessible to IHN-CCO members in terms of timeliness, amount, duration and scope as those services provided to non IHN-CCO members within the same service area.

Limiting or closing a practice

As part of your network participation, providers agree to notify SHP of any access changes that would affect members including the following:

- Closed as a PCP, open as a specialist.
- Age limitations.
- Not accepting new members.

Written notifications must be received prior to any changes taking place. This will ensure the provider directory will display the most up-to-date information for our members.

For questions or to email a notification please contact Provider Relations at **541-768-5207** or **888-435-2396**. shpprovider@samhealth.org.

Interpretation service requirements

Interpretation services are crucial in supporting access to health care for underserved populations, reducing communication barriers, developing positive patient-provider relationships and improving efficiency of health care services.

In order to meet federal and state regulations, providers are responsible for ensuring that their practice or clinic offers timely and free interpretation services to all members with limited English proficiency (LEP). Members that may be considered LEP, are individuals who do not speak English as their primary language and have a limited ability to read, speak, write

or understand English. Providers and provider clinics that receive federal funding, such as Medicare and Medicaid dollars, are required to provide these services in accordance with the Section 1557 of the Affordable Care Act, viewable at govinfo.gov and Oregon state law, which you can access at oregon.gov/oha/PH/RULESREGULATIONS.

Members are not to use adult family members as an interpreter unless the member is told that free interpreter services are available and the member specifically requests that an accompanying adult interpret instead of the free qualified health care interpreter. Children are never to be used as interpreters unless there is an emergency involving an imminent threat to the safety or welfare of an individual or the public.

Non-emergent medical transport (NEMT)

IHN-CCO members are eligible for free transportation with Cascades West Ride Line to OHP covered medical services.

To schedule a ride, the IHN-CCO member must:

- Call Monday through Friday, from 8 a.m. to 5 p.m., serving Benton, Lincoln and Linn counties.
- Schedule rides in advance to assure availability.
- If plans change, call to cancel their ride.

Ride Line works closely with members to provide transportation to their appointments. Some ride requests may require a clinician's prior authorization. Any information gathered will help determine the most appropriate transportation option for your patient. Ride Line will reach out to your clinic with these care coordination efforts.

If the member needs assistance with scheduling a ride, please feel free to coordinate that phone call. Ride Line will need the following information to schedule the trip:

- Member's first and last name.
- Date and time of the appointment.
- Address of the facility.
- Reason and duration of appointment.

Cascade West Ride Line appointments:
Call: **541-924-8738** (TTY 711)
Toll free: **866-724-2975**

Please contact SHP Provider Relations if you would like brochures (available in English and Spanish) for your office.

8.10 Provider and member relationship

Dismissing IHN members

IHN members must always be assigned to a primary care provider (PCP), therefore, guidelines are in place to ensure members continuously have access to a PCP. Please follow these guidelines:

1. Providers must notify IHN-CCO when a member has missed at least two primary care appointments with no effort on the member's part to reschedule.
   a. Scheduled and missed appointments should be documented in the member's file with the PCP.
   b. Any letters sent to the member by the PCP should also be faxed to IHN-CCO at **541-768-9364** for documentation purposes.
2. If the member **continues** to miss appointments, the provider has two (2) options:
   (a) The provider can contact IHN-CCO's Customer Service Department for assistance in outreach to the member to engage with care.

   OR

   (b) The provider may choose to dismiss the member if the provider has previously notified IHN-CCO's Customer Service Department of the missed appointments. A letter of dismissal to the member should also be faxed to IHN-CCO's Customer Service Department at **541-768-9364** and should explain, as applicable:
   - The specific reason for the dismissal.
   - The provider will provide emergency care only during the 30 days following the dismissal.
   - Specify whether the dismissal is only for the provider or for the entire clinic.
   - The member should contact IHN-CCO to arrange to choose a new PCP.

Based on the facts of the case, IHN-CCO will coordinate with the member to choose a new PCP or if the member is not engaged in this process IHN-CCO will reassign the member to another provider.

The following are not allowable reasons for dismissing a member from a practice:

- Having a physical or mental disability.
- Adverse change(s) in member's health.
- Excessive or lack of utilization of services.
- Diagnosis of end stage renal disease (ESRD).
- The member exercising his/her option to make decisions regarding his/her medical care with which the provider disagrees.
- Exhibiting disruptive or uncooperative behavior, including threats or acts of physical violence, which is a result of the member's special needs.

NOTE: *All correspondence must include two identifying points of data for the member (in addition to name), such as a date of birth and member ID. This will help IHN-CCO expedite the process and eliminate a follow-up call from us for clarification.*

Open communication

Providers are encouraged to openly communicate with members about all diagnostic testing and treatment options. Providers will not be terminated or penalized because of advocacy on behalf of members or for filing an appeal as permitted by SHP's policies, procedures and applicable laws and regulations. All communication with members must be presented in the member's preferred language and written in an understandable way.

8.11 Culturally competent services

SHP participates in the state's effort to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. These efforts ensure members have access to covered services that are delivered in a manner that meet their unique needs.

SHP expects our providers to understand the importance of cultural differences and will provide care to members without discrimination.

8.12 Advance directive and declaration of mental health treatment

An advance directive and declaration of mental health treatment allows members to express and control their health care needs at a time when they are unable to make decisions.

Advance directive

An advance directive, also called a living will, explains the specific medical decisions the member wants if they have a terminal illness or injury and are incapable of making decisions about their own care, including refusing treatment. Most hospitals, nursing homes, home health agencies and HMOs routinely provide information on advance directives at the time of admission. SHP delegates its requirement as specified in 42 CFR 422.128 and OAR 410-120-1380 to ensure members receive proper communication and instruction for completing advance directives to its contracted providers. You have agreed to this responsibility by contracting with SHP. For more information visit providers.samhealthplans.org/Resources.

Declaration of mental health treatment

A declaration of mental health treatment (DMHT) is a legal document that allows individuals to state their mental health care wishes in advance for occasions when they may become unable to communicate their wishes or to make their wishes known. The goals of completing the declaration for mental health treatment is to ensure patients are treated according to their wishes and to encourage more open dialogue between patients and their treatment providers. SHP delegates its requirement as specified in 42 CFR 422.128 and OAR 410-120-1380 to ensure members receive proper communication and instruction for completing mental health advance directives to its contracted providers. You have agreed to this responsibility by contracting with SHP. For more information visit providers.samhealthplans.org/Resources.

8.13 Provider education

SHP offers provider education materials and other informational resources at providers.samhealthplans.org. Educational training content is offered to meet CMS requirements for Special Needs Plan Model of Care (SNP-MOC) and Medicare FDR training.

Special Needs Plan Model of Care

Samaritan Health Plans (SHP) operates a Medicare Advantage Special Needs Plan (SNP) for the dual eligible population residing in Benton, Lincoln and Linn counties of Oregon. Samaritan Health Plans also operates a Medicaid managed care plan for the region, InterCommunity Health Network Coordinated Care Organization (IHN-CCO). SHP ensures that all physicians and providers permitted to practice independently under state law are properly credentialed per CMS, the Oregon Medicaid Program and SHP policies prior to providing health care services to our SNP members.

The SNP-Model of Care (MOC) annual training is offered to meet the CMS regulatory requirements for MOC Training for our SNP-MOC providers. This training also ensures all contracted network providers and out-of-network providers who regularly see our SNP members have the specialized training this unique population requires. This includes all primary care providers and family practice providers that see SNP members, as well as any specialists that see SNP members as their primary care provider.

Training must be completed on an annual basis and can be located on the SHP website at: providers.samhealthplans.org/Required-Attestations.

Medicare FDR training

First tier, downstream and related entities (FDRs) are expected to comply with all Centers for Medicare & Medicaid Services (CMS) regulatory requirements for their delegated functions. If you are contracted with us to provide administrative and/or health care services for our Medicare Advantage and/or Medicare prescription drug products (collectively, Medicare products), you are a first tier entity, as defined by CMS. As a first-tier entity, you must comply with the CMS Medicare Compliance Program requirements.

Please visit providers.samhealthplans.org/compliance for information regarding requirements for the Medicare Compliance Program.

Section 9: Members

9.1 Member rights and responsibilities

Each Samaritan health plan has a member rights and responsibilities statement specific to their member population. All the statements can be found in the member materials specific to the line of business. For Samaritan Choice Plans and IHN-CCO, the documents are referred to as handbooks. The Samaritan Advantage Health Plans are referred to as evidence of coverage and for Samaritan Employer Group Plans refer to them as certificates. The language used in the statements reflect accreditation, contract and governing entity requirements. The following are the statements for each line of business:

Samaritan Choice Plans

Your rights as a member:

- You have a right to receive information about Samaritan Choice Plans, our services, our providers and your rights and responsibilities.
- You have a right to be treated with respect and recognition of your dignity and right to privacy.
- You have a right to participate with your health care provider in decision-making regarding your health care.
- You have a right to honest discussion of appropriate or medically necessary treatment options.
- You are entitled to discuss those options regardless of how much the treatment costs or if it is covered by this plan.
- You have a right to the confidential protection of your medical information and records.
- You have a right to voice complaints about Samaritan Choice Plans or the care you receive and to appeal decisions you believe are wrong.
- You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

Your responsibilities as a member:

- You are responsible for providing Samaritan Choice Plans and our providers with the information we need to care for you.
- You are responsible for following treatment plans or instructions agreed on by you and your health care providers.
- You are responsible for payment of copays at the time of service.
- You are responsible for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.
- You are responsible for making sure services are prior authorized when required by this plan before receiving medical care.
- You are responsible for understanding your health problems and participating in developing mutually agreed upon treatment goals to the degree possible.

InterCommunity Health Network-Coordinated Care Organization (IHN-CCO) (Medicaid)

Your rights are the things you can count on getting from us. Your responsibilities are the things we need from you. As a person with IHN-CCO coverage, you have many rights and responsibilities.

As an IHN-CCO member, you have the right to:

Nondiscrimination

- Be treated with dignity and respect.
- Be treated by your providers the same as they treat all their patients.
- Get handbooks and letters that you can understand.
- Get services and support that fit your culture and language needs including auxiliary aids and services.
- Have the same access to care as all members, no matter your age or sex.
- Complain or appeal and get a response from us without a bad reaction from your plan or provider.
- Be free from getting restrained or confined, unless allowable or needed.
- Get a copy of our nondiscrimination policy.

Access

- Choose an in-network primary care provider (PCP) when you first enroll and change your PCP at other times.
- Get mental health and family planning services without a referral.
- Ask for services as close to home as possible and in a non-traditional setting that is easier for you to use.
- Get a sexual abuse exam, if needed, without prior approval.
- Get care when you need it, any time of day or night (including weekends and holidays), with no prior approval required.
- See a specialist without a referral.
- Get some health services on your own if you are younger than 18. Learn more at: oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/Documents/minor-rights.pdf

Care

- Actively help develop your treatment plan or have family involved in your treatment plan.
- Get information about Oregon Health Plan (OHP)-covered and non-covered treatment options for your condition.
- Agree to or refuse treatment (except for court-ordered services) and be told how that treatment will affect you.
- Get the tests you need to find out what condition you have.
- Get coordinated care and services that are specific to your needs and are medically needed.
- Have steady and stable contact with a care team that is in charge of your complete care management.
- Get covered services that help you stay healthy.
- Have a medical chart kept up to date by your doctor.
- See and get a copy of your medical chart, unless there is a legal reason that does not allow it. You may ask to change or correct what is in your chart.
- Have your medical chart sent to another provider.
- Have an advance directive or power of attorney and have your providers follow it.
- Get a letter if you are denied a service or if there is a change in service. You may not get a letter if the law does not require it.
- Be told ahead of time if your appointment is not going to happen.
- Get covered services without owing copays.
- Get a second opinion from a doctor in our network. If you need a doctor outside our network, we can help you find one. You can get a second opinion at no cost to you.
- Get your provider's opinion on treatment available to you.

Support

- Have a friend, family member or helper come to your appointments.
- Have a helper that will coordinate your care in the best location for you.
- Ask us how to connect to people who can support your overall health and well-being.
- Ask for a hearing with the state, if you do not agree with our appeal answer.
- Get an interpreter approved by the state, at no cost to you.
- Share your concerns with the OHP ombudsperson. They can help advocate for you.

When you applied for the Oregon Health Plan (OHP), you agreed to give true and correct information. This section tells you more about other things you need to do as an IHN-CCO member.

As an IHN-CCO member, you agree to:

- Find a doctor or other provider you can work with and tell them about your health.
- Treat providers and their staff with the same respect you want.
- Be on time for appointments.
- Call your provider at least one day before your appointment, if you cannot make it.
- Have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy.
- Go to your primary care provider (PCP) for all your health care needs, unless it is an emergency.
- Contact your provider before going to urgent care or the emergency department, unless your condition is life threatening.
- Be honest with your provider so your medical record is correct.
- Help your provider get medical records from other providers. You may need to sign a paper to give approval.
- Ask questions when you do not understand.
- Use your medical care team resources to make informed choices about your care.
- Help your provider create a care plan.
- Follow the treatment plan you agreed to with your medical care team.
- Tell your provider you have IHN-CCO and show them your ID card if they ask for it.
- Call Oregon Health Plan (OHP) Client Services at **800-699-9075** when you or a family member move in or out of your house or you change your phone number. Also, tell them when you become pregnant, are no longer pregnant or have a baby.
- Call OHP Client Services at **800-699-907** to report any other health insurance. You can also report other health insurance at reporttpl.org.
- Pay for services you agree to get that are not covered by IHN-CCO.
- Provide IHN-CCO facts about other sources who are paying for your care. Pay back IHN-CCO for any bills we paid if you get a medical settlement.
- Tell IHN-CCO if you have a complaint or grievance.

Samaritan Advantage Health Plans (HMO) (Medicare)

The rights and responsibilities for Samaritan Advantage Health Plans members are described in chapter 8 of the Evidence of Coverage for Premier Plan, Premier Plan Plus and SNP members and in chapter 6 for Conventional Plan members. Please refer to the Evidence of Coverage for additional details. The bullet points below represent only the main concepts contained in the chapters.

Samaritan Health Plans must honor your rights as a member of the plan:

- We must provide information in a way that works for you (in languages other than English, in Braille, in large print or other alternate formats, etc.).
- We must ensure that you get timely access to your covered services and drugs.
- We must protect the privacy of your personal health information.
- We must give you information about our organization and its services, the plan, its network of providers and your covered services.
- We must support your right to make decisions about your care.
    - You have the right to know your treatment options and participate in decisions about your health care.
        - To know about all your choices.
        - To know about the risks.
        - The right to say “no”.
        - To receive an explanation if you are denied coverage for care.
    - You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.
- You have the right to make complaints and to ask us to reconsider decisions we have made.

You have some responsibilities as a member of the plan:

- Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Help your doctors and other providers help you by giving them information, asking questions and following through on your care.
- Be considerate.
- Pay what you owe.
- Tell us if you move.
- Call Samaritan Health Plans Customer Service for help if you have questions or concerns at **541-768-4550** or toll free **800-832-4580**.

Samaritan Employer Group Plans

Your rights as a member

- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of your dignity and right to privacy.
- A right to participate with your health care provider in making decisions regarding your care.
- A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have a right to the confidential protection of your medical information and records.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- You have the right to continue care from an individual provider for a limited period of time after the medical services contract terminates.

Your responsibilities as a member

- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
- A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the best degree possible.
- A responsibility for payment of copays at the time of service and to be on time for that service.
- A responsibility for reading and understanding all materials about your health plan benefits and for making sure that family members covered under this plan also understand them.

9.2 Second opinions

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) provides members with opportunities to seek a second opinion from a qualified health care provider within the network or arranges for a second opinion outside of the network, at no cost to the member.

Section 10: Publications and tools

10.1 Provider directories

SHP provider directories are a valuable tool for identifying participating providers that are contracted to provide health care services to our members. The online directories provide an up-to-date listing of providers along with their contact information and any limitations.

Each line of business we offer has a designated directory that is searchable by provider specialty, location or keyword. Provider information contained in the online directories is updated at the close of each business day from information received from our provider network. Although we update the online directories daily, members are encouraged to check with the provider before scheduling an appointment to confirm they are still participating. We do not guarantee that providers listed in the directories are accepting new members. In order for Samaritan Health Plans to provide the most accurate provider information to our members, please submit any changes or updates within 30 days at providers.samhealthplans.org/Update-Your-Info.

10.2 Newsletters

The SHP provider e-newsletter is distributed via email on a quarterly basis to contracted providers and their support staff. The newsletter offers timely information about plan changes, education and training, quality metrics and other industry-related topics. To sign up for the newsletter, visit providers.samhealthplans.org/Subscribe.

10.3 Website

SHP's website address is samhealthplans.org. The website is a frequently updated tool that will serve as one of your greatest resources.

Once navigated to the provider section of the website, you'll find information including:

- Benefits and eligibility – information on benefits, formularies, eligibility, appeals and prior authorizations.
- Billing – learn about claim submission options, reimbursement guidelines and how to enroll in EFT/ERA.
- Provider Connect – your provider portal where you can check claim status, submit authorizations and check eligibility.
- Update your information – forms to add a line of business, provider changes and demographic updates.
- News and articles – all newsletters and plan updates can be found on our website.

10.4 Provider Connect

Uses

Provider Connect is the secure provider portal that gives providers and support staff access to Samaritan Health Plan members:

- Eligibility.
- Claim status/payment information.
- Submit authorizations.
- Manage member panels (for PCPs).

Registration

Provider Connect is accessed through OneHealthPort and is available 24 hours a day. If you do not have an account with OneHealthPort, you will need to register first before you can get access to Provider Connect.

Assistance

If you have any questions regarding access or navigation, SHP offers a tutorial on our website or our Provider Relations team can be reached at **541-768-5207** or shpprovider@samhealth.org.

Section 11: Health information technology (HIT)

Health information technology (HIT) involves the exchange of health information in an electronic environment. Widespread use of HIT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork and expand access to affordable health care. It is imperative that the privacy and security of electronic health information be ensured as this information is maintained and transmitted electronically. SHP utilizes several platforms to integrate HIT into its everyday practices, such as:

11.1 Health information exchange (HIE)

An HIE is the electronic movement of health-related information among organizations according to nationally recognized standards. HIE is also sometimes referred to as a Health Information Network (HIN). As defined by AHIMA – American Health Information Management Association.

11.2 Electronic health record (EHR)

An electronic health record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also can support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management and outcomes reporting.

EHRs are the next step in the continued progress of health care that can strengthen the relationship between patients and clinicians. The data, timeliness and availability of the data, will enable providers to make better decisions and provide better care.

For example, the EHR can improve patient care by:

- Reducing the incidence of medical error by improving the accuracy and clarity of medical records.
- Making the health information available, reducing duplication of tests, reducing delays in treatment and help patients stay well informed to make better decisions.
- Reducing medical error by improving the accuracy and clarity of medical records.

For information about the Medicare & Medicaid EHR Incentive Programs, please see the link in the Related Links Inside CMS section below.

For industry resources on EHR, please see the links in the Related Links Outside CMS section. cms.gov/Medicare/E-health/ehealthrecords/index.

11.3 Collective Plan/Emergency Department Information Exchange (EDIE)

Collective Plan is a web-based tool that provides real time information to support statewide efforts to reduce emergency department (ED) utilization, improve transitions of care and enhance care coordination.

Collective Plan is a complementary product to EDIE that enables hospital event information (ED and inpatient admissions and discharges) to be sent to health plans, CCOs, primary care, behavioral health, post-acute and specialty providers for specified member or patient populations. This information provides the ability to rapidly identify at-risk patients or members and support them in getting the right care through improved care coordination.

11.4 Unite us

A software platform to provide electronic closed-loop referrals, proactively identify service gaps and at-risk populations, leverage outcomes data to act and empower community organizations to accountably track outcomes collaboratively. Unite Us is used by community partners, care coordinators, health plan operations and clinical staff.

11.5 eHealth Exchange

Active in all 50 states, the eHealth Exchange is the largest query-based, health information network in the country. It is the principal network that connects federal agencies and non-federal organizations, allowing them to work together to improve patient care and public health.

The eHealth Exchange is a rapidly growing network in the U.S. comprised of partners who can share health information over the internet. Developed under the supervision of the U.S. Office of the National Coordinator for Health Information Technology, the platform makes use of a standardized approach for exchange participants. This, apart from secure sharing of clinical information, also helps in eliminating one-off legal agreements and other modifications. The eHealth Exchange currently spans all 50 states, four federal agencies, approximately 50 percent of U.S. hospitals, approximately 26,000 medical groups, 100 million patients and 8,300 pharmacies.

The eHealth Exchange was formerly known as the Nationwide Health Information Network.

12.1 Compliance and integrity program and disciplinary standards

SHP strives to ensure compliance with federal, state and local laws and regulations that apply to the health insurance industry and to each contract. We are committed to comprehensive compliance with contractual, legal and ethical expectations. Our policies and procedures reflect the organization's goal to meet or exceed compliance standards. State and federal regulations expect us to share our standards of conduct with our delegated entities (including providers) and ensure that these entities adhere to our standards or that these entities adopt and follow their own standards of conduct. These standards reflect a commitment to detecting, preventing and correcting noncompliance with regulatory requirements, including detecting, preventing and correcting fraud, waste and abuse.

Copies of the Corporate Integrity Program policies and procedures, disciplinary standards, FWA prevention handbook and other compliance-related materials can be found at our delegated entity webpage: providers.samhealthplans.org/Compliance.

All participating SHP provider clinics must adopt and implement an effective compliance program, which must include measures that prevent, detect and correct non-compliance with state and federal program requirements, as well as, fraud, waste and abuse. Training and education must occur at a minimum annually and must be a part of new employee orientation, new delegated entities and new appointment to a chief executive, manager, or governing body member. Required FWA training is developed and provided by CMS and is available through the CMS Medicare Learning Network (MLN) at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/mlnproducts. CMS has provided two training modules to fulfill this requirement:

- Medicare Parts C and D general compliance training.
- Combating Medicare Parts C and D fraud, waste and abuse training.

Once an individual completes the training, the system will generate a certificate of completion.

Copies of your completed training attendance logs and completion certificates must be made available for audit upon request by Samaritan Health Plans or CMS.

12.2 Notice of Privacy Practices and HIPAA

Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) providers are responsible for safeguarding member's personal health information (PHI). Disclosure of any PHI is limited to the minimum necessary and a disclosure form is required prior to any release of PHI. All participating providers are required to comply with HIPAA privacy and security rules and regulations.

12.3 Conflict of interest

Disclosure and attestation

According to state and federal regulations, SHP is expected to regularly audit conflict of interest attestations from our delegated entities. We require annual completion of these certifications because it ensures that each delegated entity has effectively screened managers, officers and directors responsible for the administration or delivery of Medicare Advantage and Part D benefits. A conflict of interest statement that is signed annually or upon hire, attests that the manager, officer or director is free from any conflict of interest in administering or delivering these benefits. Conflicts must be reported to the Samaritan Health Plans Compliance Department immediately upon discovery.

Our conflict of interest policy documents and attestation are available for download on our provider website:

Review our Conflict of Interest policy: providers.samhealthplans.org/Conflict-of-Interest-Policy.

Download the Conflict of Interest attestation: providers.samhealthplans.org/Conflict-of-Interest-Attestation.

12.4 Fraud, waste and abuse

The purpose of our Fraud, Waste and Abuse (FWA) program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. Our FWA prevention plan has two main functions:

- Payment integrity.
  - Ensure reimbursement accuracy.
  - Keep up to date on new and emerging FWA schemes.
  - Discover methodologies and technologies to combat FWA.
- Special investigations units (SIUs):
  - Perform prospective and retrospective investigations of suspected FWA committed against our benefit plans and programs.

This plan is part of our Compliance and Integrity program led by our compliance officer. Our Compliance Department works closely with internal departments in developing, implementing and maintaining the program.

Identifying and reporting fraud, waste and abuse is everyone's responsibility. SHP takes this very seriously and holds all employees, members and providers accountable for reporting all concerns of fraud, waste and abuse.

Examples of fraud, waste and abuse by a provider:

The types of questionable provider violations investigated by SHP include, but are not limited to the following:

- A provider knowingly and willfully referring a member to health care facilities in which or with which the provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a SHP member for covered services. This includes asking the member to pay the difference between the discounted and negotiated fees and the provider's usual and customary fees.
- Billing and providing for services to members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.

- Billing under an invalid place of service in order to receive or maximize reimbursement.

Providers in our network are responsible for auditing themselves and reporting any findings that would have resulted in an overpayment or underpayment to them.

If you identify compliance issues and/or potential FWA, report it to us immediately so we can investigate and respond appropriately.

- Call or email the SHP compliance officer, SHPOCompliance@samhealth.org.
- Email Samaritan Health Plans' Compliance Department at SHPOcompliance@samhealth.org.
- Call Ethics Point Hotline: **866-297-0489** (anonymous; optional to provide your name).
- Ethics Point Online ethicspoint.com/domain/en/default_reporter.

SHP prohibits any form of retaliation against you if you make a report in good faith.

12.5 Deficit Reduction Act of 2005 (DRA)

The Deficit Reduction Act ("DRA") aims to cut fraud, waste, and abuse from the Medicare and Medicaid programs. Health care entities like SHP who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with SHP, providers and their staff have the same obligation to report any actual or suspected violation of Medicare or Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse.
- Whistleblower protection rights as whistleblowers.

For more information on these policies, visit: providers.samhealthplans.org/Compliance

12.6 False Claims Act

The False Claims Act (justice.gov/civil/false-claims-act) is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including Medicare and Medicaid providers, every year. Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $11,181 to $22,363 per false claim.

12.7 Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of HIPAA. The law makes it illegal to offer money or services that are likely to influence a member to select a particular care provider, practitioner or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment.
- Waiving copayments and deductibles.

Providers who violate this law may be fined up to $10,000 for each wrongful act. Fines may be assessed for up to three times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable gratuities: Items or services offered to members for free must be worth less than $10 and total less than $50 per year per beneficiary. Never give cash or gift cards to members.

12.8 Exclusion checks

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers and sub delegates who are involved in or are responsible for the administration or delivery of Medicare Advantage and Part D and Medicaid benefits or services.

What you need to do:

- Make sure that potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:
  - Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov/exclusions.
  - General Services Administration (GSA) System for Award Management at SAM.gov.
- Review the exclusion lists every month and disclose to SHP any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs.
- Maintain a record of exclusion checks for 10 years. SHP or CMS may request documentation of the exclusion checks to verify they were completed.

12.9 New Preclusion List policy

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after Jan. 1, 2019. The preclusion list applies to both Medicare Advantage plans as well as Part D plans.

The preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the preclusion list, via letter and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with SHP.

Once the preclusion date is effective, claims will no longer be paid, pharmacy claims will be rejected and the provider will be terminated from the SHP network if they are contracted, until such time the provider is removed from the preclusion status.

As contracted providers of SHP, you must ensure that payments for health care services or items are not made to individuals or entities on the preclusion list, including employed or contracted individuals or entities.

12.10 Seclusion and restraints

SHP requires contracted providers to have a policy and procedure regarding the use of restraints and seclusion as required under the Code of Federal Regulations and requires the contracted provider to provide a copy of their policy to SHP upon request. If a provider is not required to maintain a policy regarding the use of restraints and seclusion, SHP requires that the provider submit a prohibited procedure or written statement to that effect.

12.11 Stark Law: Provider self-referrals

The Stark Law prohibits certain provider referrals for designated health services that may be paid for by Medicare, Medicaid or other state health care plans. The Stark Law provides that if a provider (or an immediate family member of a provider) has a financial relationship with an entity, the provider may not make a referral to the entity for the furnishing of designated health services for which payment may be made under Medicare or Medicaid. A financial relationship under the Stark Law consists of either (1) an ownership or investment interest in the entity or (2) a compensation arrangement between the provider (or immediate family member) and the entity.

The Stark Law includes many exceptions, which may apply to ownership interests, compensation arrangements or both. Unlike the Anti-Kickback Statute, which recognizes that arrangements falling outside of the safe harbors may still be permitted, the Stark Law is a strict prohibition against self-referrals; accordingly, if a referral arrangement does not meet one of the exceptions, it will be considered unlawful.

Violators of the Stark Law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000 and in certain cases, not to exceed $100,000 per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute or investment interest in any entity providing the designated health service. A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a provider (or an immediate family member of such provider) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

More information on the Stark Law can be found in Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn).

12.12 Anti-Kickback Statute (AKS)

The AKS is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals and excessive compensation for medical directorships or consultancies.

12.13 Public health emergency

In the event of a national public health emergency, SHP shall follow guidance from federal and state governing bodies as it relates to treatment, benefit coverage, reimbursement and discretionary funding allocations. In the event there are inconsistencies between federal and state guidance and the participating provider agreement, federal and state guidance shall supersede. This includes but is not limited to, reimbursement, benefit coverage and prior authorization requirements.

Section 13: Additional resources

To further assist you in working with SHP and our members, we have included a few additional links that will provide you with valuable resources.

- Samaritan Health Plans' Provider website: providers.samhealthplans.org.
- Provider newsletter: Sign up for our e-newsletter to receive important news and updates. providers.samhealthplans.org/Subscribe.
- Provider Connect: Your provider portal that gives you access to member eligibility, benefits, claims and authorization information. You can access Provider Connect through OneHealthPort which requires a one-time registration. providers.samhealthplans.org/Provider-Portal.
- Update information for a provider group or practitioner. providers.samhealthplans.org/Update-Your-Info.
- EFT/ERA enrollment: Get paid faster by enrolling in electronic funds transfer (EFT) and electronic remittance advice (ERA). providers.samhealthplans.org/EFT-ERA-Enroll.
- Oregon Health Authority: Oregon Health Plan fee-for-service fee schedule. Oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx.
- Centers for Medicare & Medicaid Services (CMS). cms.gov/Medicare/Medicare.

Section 14: Glossary of terms

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary costs to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Affiliate: A company in which SHP or any parent or subsidiary corporation of SHP owns 51% or more of the voting stock or other ownership interest.

Balance billing: The practice of a health care provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

Behavioral health care: Treatment of mental health and/or substance abuse disorders.

Birth doula: A traditional health worker that provides support to members and their family during pregnancy, childbirth and after giving birth.

Capitation: A method of paying for medical services on a per-person rather than a per-procedure basis.

Certified recovery mentor: Focuses on supporting the member through recovery from addiction and have personal experience with addiction.

Clean claim: A clean claim shall be one that is:

a. Submitted within the time frames set forth in the provider agreement and the Provider Manual.
b. Contains appropriate and sufficient medical and patient data to allow SHP to pay the claim.
c. Does not involve a coordination of benefits issue or subrogation.
d. Is submitted electronically in accordance with the formatting and submission requirements that may be established by SHP from time to time.
e. Has no defect, error, impropriety or other circumstance that would prevent the timely processing of the claim.

Coinsurance: Coinsurance refers to the percentage cost of a covered service that a member is required to pay for covered services under the member's plan.

Community health worker: A type of traditional health worker that helps members adopt healthy behaviors and navigate the health care system.

Coordinated Care Organization (CCO): A way to manage physical, mental and dental health care for the Oregon Health Plan (OHP). A CCO is a group of local health care providers, hospitals and health insurance plans that provide health care and health care coverage for people eligible for the Oregon Health Plan.

Coordination of benefits (COB): The allocation of financial responsibility for payment of covered services between two or more payers.

Copayment: Copayment shall refer to a charge required under the member's plan that must be paid by the member at the time they receive covered services.

Covered services: Covered services refers to medically necessary health care services and supplies that are:

a. Within the scope of a provider's license and practice.
b. Routinely provided to patients by a provider.
c. Covered under the terms of the member's plan.
d. Provided in accordance with the terms and conditions of the provider agreement.

Credentialing: This refers to a process of screening, selecting and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status and judgment.

Deductible: A deductible is the amount that a member must pay for covered services for a specified period in accordance with the member's plan before benefits will be paid. A deductible is not coinsurance or copayment.

Durable medical equipment (DME): Equipment that can be repeatedly used, is primarily and customarily used to service a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.

Emergency or emergency medical condition: An emergency or emergency medical condition refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that would lead a prudent layperson to believe that the absence of immediate medical attention would result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or unborn child).
b. Serious impairment of bodily functions.
c. Serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions:
    a. There is inadequate time to affect a safe transfer to another hospital before delivery.
    b. A transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency services: Emergency services are those provided to treat an emergency or emergency medical condition, as covered by the terms of the member's plan.

Episode of care: All treatment rendered in a specified time frame for a specific disease.

Experimental or investigational procedures: These procedures are also known as unproven therapies. As determined by SHP, experimental or investigational procedures are services, supplies, drugs or devices that are not recognized as standard medical care for the condition, disease, illness or injury being treated, including non-FDA approved drugs or therapies.

Fee-for-service: The traditional method of paying for medical services. A provider charges a fee for each service provided and the insurer pays all or part of that fee.

Formulary: A list of medications that are eligible for coverage under the terms of a member's plan.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR § 455.2)

Health equity: When everyone has a fair and just opportunity to be as healthy as possible, regardless of social position or other social circumstances.

Health systems division: Comprised of the Medical Assistance Program, which operates the Oregon Health Plan, Addictions and Mental Health.

IHN-CCO: InterCommunity Health Network Coordinated Care Organization.

Managed care entity: an entity that enters into a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans and primary care case managers.

Medically necessary/medical necessity: Medically necessary and medical necessity refers to health care services and supplies that SHP determines are required to treat a member's condition and are authorized by the terms of the member's plan. All determinations of medically necessary and/or medical necessity shall be made in accordance with SHP policies, the Provider Agreement and the Provider Manual. Any service that is determined to not be medically necessary is a non-covered service.

Member: A member is a person who is eligible to receive covered services under his or her plan at the time the provider renders services pursuant to the Provider Agreement.

Member encounter data: Member encounter data refers to the specific data collected during a patient encounter or a series of patient encounters, that substantiates a member's health condition or disease.

Network: The providers, clinics, health centers, medical group practices, hospitals and other providers that Samaritan Health Plans has contracted with to provide health care for its members.

Non-covered services: Non-covered services are services that are determined by SHP to not be medically necessary. They are not covered by the member's plan. SHP is not required to reimburse providers or pay any claims related to a non-covered service.

Non-participating provider: A non-participating provider is any person or entity that provides otherwise covered services, but who has not entered into an agreement with SHP.

Participating provider: A participating provider is any provider, hospital, skilled nursing facility or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into an agreement with SHP to provide covered services to SHP's members and who has been credentialed by SHP or its designee.

Payer: Payer shall mean an employer, insurer, health maintenance organization, labor union, SHP, IHN-CCO and/or any other person or entity which has agreed to be responsible for funding benefit payments under the terms of the plan.

Peer support specialist: A traditional health worker that focuses on supporting members through recovery from addiction and/or mental health conditions.

Peer wellness specialist: A traditional health worker that works as part of a person-driven, health home team, they combine behavioral health and primary care to assist and advocate for members in achieving well-being.

Personal health navigator: A traditional health worker that provides information, assistance, tools and support to help members make the best health care decisions.

Plan: Plan refers to any health benefit product or plan issued, administered, or serviced by SHP or any of its subsidiaries or affiliates, including, but not limited to, commercial health insurance products, Medicare Advantage and Medicaid.

Plan allowable: This refers to the lessor of (1) billed charges or (2) total allowed amount as determined in the applicable rate exhibits and any plan limitations relating to covered services, such as prior authorization requirements. In consideration of medically necessary covered services that a provider renders to members, SHP shall reimburse the provider for timely filed clean claims up to a maximum amount of the plan allowable.

Primary care provider: A primary care provider, also known as a PCP, refers to a participating provider who is duly licensed to practice medicine and who has the primary responsibility for providing primary care services to members. A PCP may be a general practitioner, internist, pediatrician, obstetrician, gynecologist, family practitioner or any other specialty that has been approved to act as a PCP pursuant to the Oregon Revised Statutes.

Prior authorization: Prior approval obtained by a provider from SHP for covered services defined by SHP requiring authorization for payment.

Proprietary information: Proprietary information refers to information that has been developed or belongs to SHP or a related payer, which is intended to remain confidential. This information includes, but is not limited to, the Provider Agreement, mailing lists, patient lists, employer lists, payer rates and procedures, product related information and structure, utilization review processes and procedures, quality improvement processes and procedures and any other information which SHP marks as proprietary, confidential or which SHP reasonably believes is proprietary or confidential.

Provider: This refers to the person or entity that has executed the Provider Agreement, as indicated on the signature page and who has met all credentialing and/or re-credentialing requirements. In the event the provider is a group of health care service providers, the term shall encompass all the providers associated with the provider executing the Provider Agreement.

Quality Improvement Program: The Quality Improvement Program (QIP) is a program designed by SHP to monitor the quality of care and services that are received by SHP members as covered services.

Referral: The process by which the member's primary care provider directs the member to obtain covered services from other providers and providers.

SHP: Samaritan Health Plans

Social determinants of health (SDoH): Conditions in which people are born, grow, live, work and age. These conditions include housing, food, employment, education and many more. Social determinants of health can impact health outcomes in many ways, including determining access and quality of medical care.

Subrogation: The process by which SHP may recover from another insurance carrier benefits paid on behalf of a member, where the legal obligation to pay benefits regarding a claim rests with the other carrier.

Telehealth or telemedicine: Professional services with a qualified health care provider, provided in real-time over an electronic mechanism. Services are rendered to patients using electronic communications such as secure email, patient portals and online audio and/or video.

Traditional health worker (THW): A community health worker, peer wellness specialist, personal health navigator, peer support specialist or birth doula. All THWs provide resources, education and work with members to promote healthy behaviors and link members to resources in their community.

Utilization: The extent to which the members of a covered group use the services or procedures of a particular health care benefit plan.

Utilization review: A set of formal techniques used by an insurer that are designed to monitor the use or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

Waste: Health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, under-use and ineffective use. Inefficiency waste includes redundancy, delays and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to the Medicaid program.

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