Trillium Community Health Plan®

Provider Manual

January 1, 2026

Current as of January 1, 2026. Please see trilliumohp.com/providers/resources/forms-resources.html for updates.

1-877-600-5472
TTY 711

TrilliumOHP.com

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Introduction

WELCOME

Welcome to Trillium Community Health Plan (Trillium). Thank you for being part of the Trillium network of participating physicians, hospitals, and other healthcare professionals.

ABOUT TRILLIUM COMMUNITY HEALTH PLAN

Trillium Community Health Plan is a Coordinated Care Organization (CCO) partnering with physical, behavioral, and oral healthcare organizations as well as organizations addressing social determinants of health and equity on behalf of Oregon Health Plan (OHP) members in Washington, Multnomah, Clackamas, Lane, Western Douglas, and Western Linn counties.

A CCO is a network of all types of healthcare providers (physical healthcare, addictions and mental healthcare, and dental care providers) who work together in their local communities to serve people who receive healthcare coverage under OHP. CCOs focus on prevention and helping people manage chronic conditions like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. Today, there are 16 CCOs operating in communities around Oregon.

Key elements of the coordinated care model include:

- Best practices to manage and coordinate care
- Maintaining costs at a sustainable rate of growth
- Paying for outcomes and health
- Measuring performance
- Shared responsibility for health
- Transparency and clear information

As a leader in innovative approaches and outstanding coordination of community-based healthcare, Trillium remains steadfast in our commitment to improving the health of our community by working toward mutually shared goals of reduced health disparities and better care at lower costs.

Trillium does this through our focus on the individual, whole health, and local involvement.

Focus on Individuals: We believe treating people with kindness, respect, and dignity empowers healthy decisions, and that healthier individuals create more vibrant families and communities.

Whole Health: We believe in treating the whole person, not just the physical body.

Active Local Involvement: We believe local partnerships enable meaningful, accessible healthcare.

TRILLIUM'S VISION

Our vision is to create a resilient, community-based healthcare system that focuses on prevention and the health of our members through coordination, collaboration, and the elimination of health disparities.

TRILLIUM'S MISSION

Transforming the health of the communities we serve, one person at a time.

TRILLIUM'S COMPLIANCE PROGRAM

Trillium is committed to providing member-focused whole healthcare while also complying with federal and state law. Trillium's Compliance Department guides the ethical practices of our health plan and actively encourages employees and providers, through training and education, to perform their roles in providing quality care to the highest legal and ethical standards. Trillium encourages reporting of compliance concerns. Contact information may be found under the "Contact Us" section of this manual.

ABOUT THIS MANUAL

This manual has been developed as a resource for important operational information concerning the role of the provider and staff in the delivery of healthcare to Trillium members. Our responsibility to our contracted providers is to ensure that essential and helpful information is readily available. Though this manual is provided as an informational resource for Trillium providers, it is not all-inclusive and should be used in conjunction with your contract and regular communication updates.

In addition to the detailed operational and policy information in this manual, we encourage you to visit our public website at www.trilliumohp.com where you'll find additional important provider information and frequently used online tools for serving Trillium members.

CONTACT US

Trillium administrative staff is available 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays.

Resource	Contact
Appeals & Grievances	877-600-5472
Medical Authorizations	877-600-5472, select option #3 for 'healthcare provider' and select option #4 for 'authorizations'
Behavioral Health Authorizations (Phone)	833-616-0645
Behavioral Health Prior Authorization (Fax)	833-505-1300
Billing & Claims	877-600-5472 Trillium Community Health Plan, Attn: Claims P.O. Box 5030 Farmington, MO 63640-5030
Trillium Compliance	ComplianceOregon@centene.com
Compliance Hotline (anonymous)	800-345-1642
Fraud, Waste and Abuse Hotline	866-685-8664
Confidential Complaint Hotline	877-367-1332
Credentialing/Enrollment Services	877-600-5472 Fax: 844-890-4957 TCH_ProviderOperations@Centene.com
Population Health	877-600-5472
Member Services	877-600-5472
OHA Provider Services	800-336-6016
Pharmacy	833-913-1004
Provider Services	877-600-5472
Website	www.trilliumohp.com

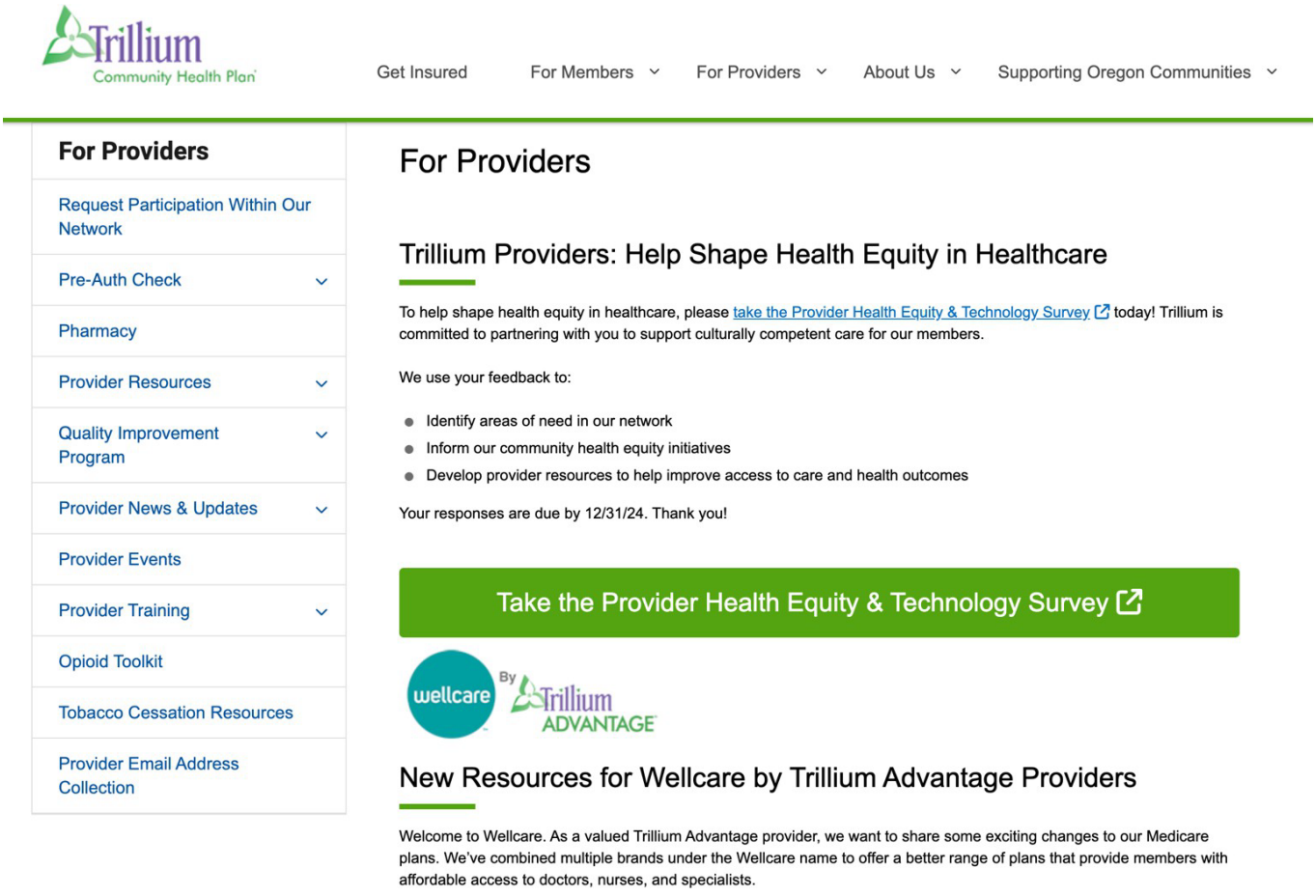
Trillium Provider Resources

TRILLIUM WEBSITE trilliumohp.com/providers

The Trillium website provides general health plan information to our members and providers. The Provider Resources page on the website includes policy and procedure updates, news and events, formularies, the Pre-Auth Check Tool, and many other helpful resources.

Included on the Provider Resources page:

- Authorization Forms
- Provider Communications Archive
- Billing Manual
- Provider Training
- Formulary
- CCO Metrics
- Pre-Authorization Check Tool



PROVIDER PORTAL

Trillium's provider portal allows secure online access to information stored on Trillium data systems. The Trillium provider portal complies with all CMS and HIPAA specifications regarding patient information and internet security and uses secure client/server technology to exchange information between your office and Trillium.

Trillium's secure provider website enables providers to perform several functions such as: check member eligibility and benefits, submit and check status of claims, submit claims adjustments, submit

authorizations, and view history and status for claims, referrals, and prior authorizations for physical health, DME, and behavioral health.

The Trillium provider portal is available to all providers and practitioners in the Trillium network. Registration is required for full access. The provider portal may be found at: https://provider.trilliumhealthplan.com/.

Traditional Health Workers

Traditional Health Workers (THW) are frontline public health workers who work in the community or clinical settings under the direction of a licensed health provider.

Oregon Health Authority recognizes the following categories of THWs:

- Birth Doula – provides non-medical support to women and families through all stages of pregnancy (prenatal, childbirth, and post-partum care)
- Community Health Worker – provides services with an understanding of the community being served to support achievement of positive health outcomes
- Peer Support Specialist (PSS) – provides supportive services to a current or former consumer of mental health or addictions treatment
- Peer Wellness Specialist (PWS) – provides supportive services to a current or former consumer of mental health or addictions treatment with physical conditions
    - Family Support Specialist – an individual who meets qualification criteria under ORS 414.665 and is certified as either a PSS or PWS and who, based on similar life experiences, provides support services to and has experience parenting a child who
        - is a current or former consumer of mental health or addiction treatment; or
        - is facing or has faced difficulties in accessing education, health, and wellness services due to mental health or behavioral health barriers.
    - Youth Support Specialist – an individual who meets qualification criteria under ORS 414.665
- Personal Health Navigator (PHN) – provides information, assistance, tools, and support to enable a member to make the best healthcare decisions

Trillium has a THW Liaison who serves as a single point of contact working directly with providers, community-based organizations and other THWs on building the THW workforce and coordination of alternative payment methodologies.

The THW Liaison focuses on:

- Ensuring integration of the THWs into the delivery services
- Coordinating technical assistance to help THWs become enrolled as providers with Trillium
- Supporting providers and THWs with required OHA reporting
- Educating and encouraging the use of THWs with members, providers, and community-based organizations

To access Trillium's THW Liaison, please email THW@TrilliumCHP.com

TRADITIONAL HEALTH WORKER PROVIDER PARTICIPATION REQUIREMENTS

Traditional Health Worker (THW) Best Practices

THW providers agree to review the "THW Commission Best Practices" and the "Recommendations on Support and Supervision of Traditional Health Workers" and to abide by THW Standards of Professional Conduct as defined in OAR 950-060-0080. Providers also agree to align with the recommended qualities, skills, knowledge, and standards of excellent practice of a THW supervisor as outlined in the current THW Commission guidance document.

THW Data Collection and Reporting

Per Exhibit K in the CCO contract, the Oregon Health Authority requires Trillium to maintain reports about our THW providers, including doulas, community health workers, peer support specialists, peer wellness specialists, and personal health navigators.

To advance equity and increase access to culturally responsive care, we assess the demographic makeup of our THW workforce using Race, Ethnicity, and Language, Disability (REALD) indicators. This analysis helps us better understand how our workforce represents the demographics of the communities we serve. Note: No individual information will be disclosed.

All THW providers must complete the annual THW Reporting Template by August 31 of each year. The reporting period is the fiscal year of July 1-June 30. For example, if you are completing the form in August 2025, the reporting period would be July 1, 2024-June 30, 2025. Please fill out all sections of the form for each THW worker type you employ, then email your completed form to THW@Trilliumchp.com.

Working with Trillium Community Health Plan

PROVIDER PARTICIPATION REQUIREMENTS

Trillium requires providers to meet the following basic criteria before serving Trillium members:

- Have a current license to practice in the state of Oregon
- Meet Trillium's credentialing requirements
- Have executed a provider agreement with Trillium

Credentialing

CREDENTIALING CRITERIA AND STANDARDS FOR PARTICIPATION

All practitioners participating in Trillium's network must comply with the following criteria and standards for participation in order to receive or maintain credentialing.

Applicants seeking credentialing, and practitioners due for recredentialing, must complete all items on a Trillium-approved credentialing application and supply supporting documentation, if required. The verification time limit for a Trillium-approved application is 180 days. You may access the application at the Council for Affordable Quality Healthcare (CAQH) website by selecting the Universal Credentialing DataSource.

Supporting applicant documentation includes:

- Answers to all confidential questions and explanations provided in writing for any questions answered adversely
- Continuous work history for the previous five (5) years with a written explanation of any gaps of a prescribed time frame (initial credentialing only)
- Current active state medical license
- Evidence of active admitting privileges in good standing, with no reduction, limitation, or restriction on privileges, with at least one Trillium participating hospital or surgery center, or a well-documented coverage arrangement with a Trillium credentialed, participating practitioner of a like specialty or hospitalist group
- Evidence of adequate education and training for the services the practitioner is contracting to provide

- insurance coverage that meets Trillium standards
- Only licensed, qualified applicants meeting these standards and participation requirements are accepted or retained in the Trillium network.
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable. A practitioner who maintains professional practices in more than one state must possess a DEA certificate for each state.
- Disclosure of ownership form (DOO)

CREDENTIALING PROCESS

Practitioners or organizational providers subject to credentialing or contracting directly with Trillium must submit a completed Trillium-approved application. By submitting a completed application, the practitioner or provider:

- Affirms the completeness and truthfulness of representations made in the application, including lack of present illegal drug use
- Authorizes Trillium to obtain information regarding the applicant's qualifications, competence, or other information relevant to the credentialing review
- Indicates a willingness to provide additional information required for the credentialing process
- Releases Trillium and its independent contractors, agents, and employees from any liability connected with the credentialing review

CREDENTIALING RESPONSIBILITY, OVERSIGHT, AND DELEGATION

Trillium may delegate to individual practitioner or physician groups for activities associated with credentialing and recredentialing. Credentialing procedures used by these entities may vary from Trillium procedures, but must be consistent with health plan, state, and federal regulatory requirements and accrediting entity standards.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the overseer or delegated entity of delegated activities must meet or exceed Trillium standards. Trillium oversees delegated responsibilities on an ongoing basis through an annual audit and semi-annual or more frequent review of delegated group-specific data.

Trillium may revoke the delegation of any or all credentialing activities if the delegated group or entity is deemed noncompliant with established credentialing standards. Trillium retains the right, based on quality issues, to terminate or restrict the practice of individual practitioners, providers, and sites, regardless of the credentialing delegation status of the group.

Each practitioner or provider losing delegated credentialing status must complete Trillium's initial credentialing process within six (6) months in order to remain in the Trillium network.

CREDENTIALING STATUS: APPROVAL, DENIAL, OR TERMINATION

The Trillium Credentialing Committee or physician designee reviews the files of practitioners and organizational providers meeting all Trillium criteria and approves admittance or continued participation in the Trillium network.

A peer review process is used to determine whether a practitioner or practitioners with a history of adverse actions, member complaints, substantiated Quality of Care concerns or events, impaired health, substance abuse, healthcare fraud and abuse, criminal history, or similar conditions should be admitted or retained as a participant in Trillium's network.

Trillium notifies practitioners within 60 days of all decisions regarding approval, denial, limitation, suspension, or termination of credentialing status consistent with health plan, state and federal regulatory requirements, and accrediting entity standards. This notice includes information regarding the reason for a denial determination. If the denial or termination is based on health status, Quality of Care, or disciplinary action, the practitioner is afforded applicable appeal rights as described above.

Practitioners who fail to respond to recredentialing requests are subject to administrative termination from the Trillium network. Practitioners who have been administratively denied or terminated are eligible to reapply for network participation as soon as the administrative matter is resolved.

CREDENTIALING INFORMATION RIGHT OF REVIEW

A practitioner has the right to review information obtained by Trillium for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source, but does not extend to review of information, references, or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to Trillium's Credentialing manager or supervisor. The manager or supervisor notifies the practitioner within 72 hours of receipt when the information is available for review at Trillium's Credentialing Department. Upon written request, the Trillium Credentialing Department will provide details of the practitioner's current status in the initial credentialing or recredentialing process.

NOTIFICATIONS OF DISCREPANCY

Trillium notifies practitioners in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board certification expiration.

Practitioners are notified of the discrepancy at the time of primary source verification. Sources are not revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

PRACTITIONER CORRECTIONS OF ERRONEOUS INFORMATION

A practitioner who believes that erroneous information has been supplied to Trillium by primary sources may request correction of such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice via letter or fax, along with a detailed

explanation to the Credentialing Department manager or supervisor. The practitioner must respond and provide information to Trillium within 48 hours of Trillium's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of their credentials file. Upon receipt of notification from the practitioner, Trillium re-verifies the primary source information in dispute. If the primary source information has changed, corrections are made immediately to the practitioner's credentials file. The practitioner is notified in writing, via letter or fax, that the correction has been made. If, upon re-review, primary source information remains inconsistent with the practitioner's notification, the Credentialing Department notifies the practitioner via letter or fax. The practitioner may then provide proof of correction by the primary source body to Trillium's Credentialing Department via letter or fax within 10 working days. The Credentialing Department re-verifies the primary source information if such documentation is provided. If the primary source information remains in dispute after reverification or 10 working days, whichever is later, Trillium may terminate or deny credentialing.

PRACTITIONER CREDENTIALING APPEALS AND RECONSIDERATIONS

Trillium provides notice and opportunity for an appeal to practitioners whose participation in Trillium's network has been denied, reduced, suspended, or terminated for Quality of Care/medical

disciplinary causes or reasons. This policy does not apply to practitioners who are administratively denied admittance to, or administratively terminated from, the Trillium network.

The notice of altered participation status is provided to the affected practitioner and includes:

- Detailed instructions on how to request an appeal (informal reconsideration or formal hearing)
- The action proposed against the practitioner by the Credentialing or Peer Review Committee
- The reasons for the action
- The Trillium policies and procedures that led to the committee's adverse determination

A practitioner may choose to engage in an informal reconsideration and address the Credentialing Committee or move directly to a formal fair hearing. Affected practitioners who are not successful in overturning the original committee decision during an informal reconsideration are automatically afforded a fair hearing, upon request in writing within 30 days from the date of notice of the denial.

A practitioner must request a reconsideration or fair hearing in writing. Trillium's response includes:

- A list of practitioners and specialties of the committee or fair hearing panel members
- Date, time and location for the reconsideration or fair hearing
- Rules that govern the applicable proceedings

The composition of a fair hearing panel must include a majority of individuals who are peers of the affected practitioner. A peer is an appropriately trained and licensed physician in a practice similar to that of the affected practitioner.

Trillium grants admittance or continued participation to affected practitioners whose original actions are overturned. The fair hearing panel's decision is forwarded to the affected practitioner in writing in an expeditious manner and no more than 60 calendar days of the final decision.

Trillium grants admittance or continued participation to affected practitioners whose original determinations have been upheld in an expeditious manner and no more than 60 calendar days of the fair hearing panel's ruling. Trillium reports the actions to the applicable state licensing board and to the National Practitioner Data Bank (NPDB) within 15 days of the hearing panel's final decision.

Practitioners who have been denied or terminated for Quality of Care concerns must wait three years from the date the adverse decision is final in order to reapply for network participation.

At the time of reapplication, the practitioner must:

- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of Trillium's credentialing program
- Meet all applicable Trillium requirements and standards for network participation
- Submit additional information so the Credentialing or Peer Review committee, at its discretion, may require to demonstrate to its full satisfaction that the basis for the earlier adverse action no longer exists

PRACTITIONER CREDENTIALING INVESTIGATIONS

Trillium investigates adverse activities identified in all initial credentialing or recredentialing applications or identified between credentialing cycles. Trillium may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. Trillium may require a practitioner or provider to supply additional information regarding any such adverse activities.

Examples of such activities include, but are not limited to:

- Criminal history
- Current or past chemical dependency or substance abuse
- Healthcare fraud or abuse
- Impaired health
- Member complaints
- Office of Inspector General (OIG) Medicare/OHP sanctions
- State or local disciplinary action by a regulatory agency or licensing board
- Substantiated media events
- Substantiated Quality of Care concerns or activities
- Trended data

At Trillium's request, a practitioner or provider must assist Trillium in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within the prescribed time frames. Trillium sanctions, or exclusions.

TRILLIUM CREDENTIALING FOR OTHER PROVIDERS & SPECIALTIES

The sections below describe Trillium's policies for Organizational Providers, Primary Source Verification and Recredentialing Policies, and Recredentialing of Physicians and Other Healthcare Practitioners.

Organizational Providers

An organizational provider (OP) is an institutional provider of healthcare services that is licensed by the state or otherwise authorized to operate as a healthcare facility.

Organizational providers that require certification and recertification by Trillium or its delegated entities include, but are not limited to:

- Behavioral health facilities (inpatient, residential, and ambulatory)
- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities
- Dialysis/end-stage renal disease (ESRD) care providers
- Federally qualified health centers and rural health clinics
- Freestanding and ambulatory surgery centers, including abortion clinics
- Home health, hospice, and home infusion providers
- Hospices
- Hospitals
- Office-based surgery suites
- Other providers as deemed necessary
- Outpatient physical therapy and speech pathology providers
- Portable X-ray suppliers
- Providers of outpatient diabetes self-management training
- Radiology/imaging centers
- Skilled Nursing Facilities
- Sleep study centers
- Urgent care centers

Providers contracting directly with Trillium must submit a completed, signed Trillium-approved facility certification application and any supporting documentation to Trillium for processing.

The documentation, at a minimum, includes:

- Evidence of a current, unencumbered state facility license. If the facility is not licensed by the state, Trillium requires the facility to provide a current city license, facility name permit, certificate of need, or business registration.
- Evidence of a site survey that has been conducted by an accepted agency, if the provider is required to have such an on-site survey prior to being issued a state license. Accepted agency surveys include those performed by the state Department of Health and Human Services (DHHS), Department of Public Health (DPH), or Centers for Medicare and Medicaid Services (CMS).
- Overview of the facility's quality assurance/quality improvement program upon request
- Professional and general liability insurance coverage that meets Trillium requirements
- Copy of a current accreditation certificate appropriate for the facility. If the facility is not accredited, Trillium requires a copy of the most recent DHHS/DPH site survey as described above. A favorable site review consists of compliance with Quality of Care standards established by CMS or the applicable state health department. This may include a completed corrective action Plan (CAP) and DHHS CAP acceptance letter.

Trillium recertifies organizational providers at least every 36 months (3 years) to ensure each entity has continued to maintain prescribed eligibility requirements.

PRIMARY SOURCE VERIFICATION FOR CREDENTIALING AND RECREDENTIALING

The Credentialing Department obtains and reviews information on a credentialing or recredentialing application and verifies it in accordance with Trillium primary source verification practices. Trillium requires medical groups to which credentialing has been delegated to obtain primary source information in accordance with Trillium standards of participation, state and federal regulatory requirements, and accrediting entity standards.

The credentialing/recredentialing processes apply, but are not limited, to the following types of providers:

- Acupuncturist
- Audiologist
- Dentist and dental hygienist
- Doctor of chiropractic medicine
- Doctor of medicine
- Doctor of naturopathic medicine
- Doctor of osteopathy
- Doctor of podiatric medicine
- Licensed clinical social worker; marriage and family therapist; marriage, family and child counselor; and mental health counselor
- Nurse practitioner and certified nurse midwife
- Optometrist
- Oral and maxillofacial surgeon
- Physical therapist and occupational therapist
- Physician assistant
- Psychologist
- Speech therapist/pathologist

Organizational Providers:

- Behavioral health facilities (inpatient, residential, and ambulatory)
- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities
- Dialysis and end-stage renal disease (ESRD) care providers
- Federally qualified health centers/rural health clinics
- Freestanding and ambulatory surgery centers
- Home health, hospice, and home infusion providers
- Hospitals
- Physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology and imaging centers
- Skilled nursing facilities
- Sleep centers
- Urgent care centers

RECREDENTIALING OF PHYSICIANS AND OTHER HEALTHCARE PRACTITIONERS

Trillium's credentialing program establishes criteria for evaluating participating practitioners on a continuing basis. Trillium conducts this evaluation, which includes applicable primary source

verification, in accordance with health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Trillium retains only licensed, qualified practitioners meeting and maintaining Trillium standards for participation requirements in the Trillium network.

Trillium requires practitioners due for recredentialing to complete all items on an approved Trillium application and supply supporting documentation, if required. Documentation includes, but is not limited to:

- Attestation to the ability to provide care to Trillium members without restriction
- Current state medical license
- Evidence of active admitting privileges in good standing, with no reduction, limitation, or restriction on privileges, with at least one Trillium participating hospital or surgery center, or a well-documented coverage arrangement with a Trillium credentialed or participating practitioner of a like specialty or hospitalist group
- Malpractice insurance coverage that meets Trillium standards
- Trended assessment of practitioner's member complaints, Quality of Care, and performance indicators
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate or Chemical Dependency Services (CDS) certificate, if applicable. A practitioner who maintains professional practices in more than one state must obtain a DEA certificate for each state.
- Cultural
- Competency Continuing Education (CCCE) Attestation or Certificate

SITE VISITS, MEMBER ASSIGNMENT, LOCUM TENENS POLICIES

Site Evaluations:

Trillium's Credentialing Department reviews a Trillium practitioner office site complaint report to identify any office site deficiencies and requests an office site visit if there have been more than three complaints filed within the last six months. Trillium conducts a review of member complaint reports or related information at least every 60 days. An exception to the threshold is made if the nature of the concern may cause potential harm to Trillium members' health or safety.

Events that initiate an investigation to conduct a site visit include, but are not limited to:

- Adequacy of waiting and examining room space
- Physical accessibility
- Physical appearance

When there are member complaints, a Trillium Medical Site Coordinator or designee conducts office site evaluations using an approved Trillium Site Evaluation Tool, which examines the following:

- Adequacy of waiting and examining room space
- Equipment
- Medical record-keeping
- Other issues, including safety
- Physical accessibility
- Physical appearance

Trillium weighs each criterion on the site tool equally. If the office site audit has an overall score below 100 percent, the applicable department creates a corrective action plan (CAP) that outlines deficient criteria and the actions that need to be taken by the office.

Trillium's Credentialing Department refers practitioners who refuse an office site evaluation, do not meet the CAP within a specified time frame, or refuse to participate in a CAP to the Trillium Credentialing Committee for administrative denial or termination. This administrative denial or

termination applies to all Trillium lines of business. Sites that have complied with a CAP are retained in the Trillium network.

TERMINATED CONTRACTS AND REASSIGNMENT OF MEMBERS

Trillium notifies members as required under state law if a practitioner's contract participation status is terminated. Trillium oversees reassignment of these members to another participating provider where appropriate.

TERMS FOR LOCUM TENENS PROVIDERS

From time to time, participating providers may require assistance from locum tenens providers and/or temporary associates. In all cases, a locum tenens associate must be working for and bill under a participating provider. Trillium limits the length of time for a locum practitioner to 90 days unless the provider submits a written request explaining extenuating circumstances in writing to the Chief Medical Officer. If the Chief Medical Officer approves the request, the locum's practitioner may stay for a total of 120 days.

TRILLIUM PROVIDER RESPONSIBILITIES

It is Trillium's policy to ensure that members have access to timely, appropriate preventive and curative healthcare delivered in a culturally and linguistically appropriate manner. Trillium requires providers to have policies and procedures that prohibit discrimination in the delivery of healthcare services.

Providers shall provide Covered Services to both Covered and perspective persons without discrimination for any reason, including but not limited to:

- Race
- Sex
- Sexual orientation
- Age
- Color
- Religion
- Marital status
- National origin
- Place of residence
- Health status
- Type of payor
- Source of payment (e.g., Medicaid generally or a State-specific healthcare program)
- Physical or mental disability or veteran status
- Gender identity

Providers shall not deny, limit, or condition coverage or the furnishing of healthcare services or benefits to Covered Persons or perspective persons based on any factor related to health status, including, but not limited to:

- Medical condition (including mental as well as physical illness)
- Claims experience
- Receipt of healthcare
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Race
- Ethnicity
- National origin
- Religion
- Sex

- Age
- Sexual orientation
- Source of payment
- Mental or physical disability

RESPONSIBILITIES OF PRIMARY CARE PHYSICIAN

Primary Care Physicians (PCPs) are responsible for coordinating and managing a member's care. Trillium requires PCPs to screen members for healthcare needs, including both mental illness and substance use disorders. PCPs are also required to screen members for adequacy of home and family supports, including housing needs, nutrition, transportation needs, childcare, and safety needs. PCPs are required to use Medically Appropriate and Evidence-Based treatments in meeting members' healthcare needs. A PCP shall not refuse to treat Trillium members as long as the physician has not reached his or her requested panel size.

In addition to the above, PCPs are expected to:

- Arrange for hospitalization in a network institution when required
- Be responsible for the training and education of individuals working within the medical practice to assure that the procedures for coordinated care delivery are followed in a culturally and linguistically appropriate manner
- Contact Trillium to obtain prior authorizations in a timely manner, per the prior authorization process
- Coordinate hospital care for every hospitalized member including participation in planning for post-discharge care
- Maintain the member's medical record in accordance with the Standards for Medical Record-keeping established by Trillium and the Division of Medical Assistance Programs (DMAP)
- Provide interpretation services by staff, telephonically by a qualified interpretation service, onsite by a qualified interpretation service or by utilizing Trillium's interpretation services
- Provide or arrange for access to care for members 24 hours a day, seven days a week
- Refer members to specialists as medically necessary
- Review information from specialists to include in meeting a member's healthcare needs and incorporate it in the member's medical record

PREVENTIVE CARE SERVICES

Trillium expects practitioners to provide preventive care promoting physical, oral, and behavioral health. Preventive services include, but are not limited to, periodic medical examinations and screening tests based on age, gender, and other risk factors; screenings; immunizations; and counseling regarding behavioral risk factors. For children up to age 21, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services include medically necessary and medically appropriate services to treat any physical, dental, vision, developmental, nutritional, mental, and behavioral health condition. Trillium requires practitioners to report services rendered to members, and practitioners are subject to Trillium's Medical Case Management and Record Keeping policies.

Advance Directives Policy

Oregon allows individuals to plan for someone to make healthcare decisions on their behalf through the use of the Advance Directive form.

Trillium must ensure there is documentation that PCPs have written policies regarding advance directives and that they document in the medical record whether or not the individual has executed an advance directive. See the Oregon Health Authority website for details.

DISCUSSING ADVANCE DIRECTIVES WITH PATIENTS

The Patient Self-Determination Act (PSDA) requires providers and organizations that receive Medicare and Medicaid payment to ensure patients are given an opportunity to participate in, and direct, healthcare decisions that affect them. For patients ages 18 and older, Trillium providers are required to document in a prominent part of the medical record whether a patient has executed an advance directive. Trillium monitors medical records to ensure that compliance with requirements related to a patient's advance directive is met.

An advance directive outlines a patient's preferred types of healthcare services and treatments and designates who is to speak on the patient's behalf if they become incapable of making personal healthcare decisions. According to the PSDA, patients with decision-making capabilities have the right to accept or refuse medical treatment or life-sustaining procedures. Trillium's policy states that adult members ages 18 or older have the right to prepare an advance directive. Providers should routinely discuss advance directives with their patients during office visits instead of waiting until they may be acutely ill.

Discussing and preparing advance directives with patients can:

- Designate the person who is delegated to make decisions on the patient's behalf if they become incapable of making such decisions
- Ensure family and friends abide by the wishes of the patient regarding the type of care and treatment determined in advance
- Ensure the care and services desired by the patient are provided according to their wishes, including refusal of treatment

Providers should encourage patients who have prepared advance directives to share copies with their families to notify them about who is designated to make decisions on their behalf in the event they can no longer make personal healthcare decisions. Providers may initiate early healthcare planning discussions to enable a smoother transition before a medical crisis arises. On an annual basis, providers must document in the patient's medical record whether advance directives have been discussed, including the date the discussion was held, and whether an advance directive has been executed.

Responsibilities of Specialists

Trillium instructs members to ask their PCPs to coordinate care with specialists, who may see a referred member, regardless of diagnosis, without prior authorization.

Specialists are required to:

- Advise the PCP if follow-up treatment is necessary
- Deliver care in a culturally and linguistically appropriate manner
- Educate and train all individuals working within their medical practice to ensure individuals follow Trillium coordinated care procedures and policies correctly
- Ensure documentation and incorporation of treatment and preventive services into the member's medical record, as necessary
- Notify the member when the requested service has been approved
- Obtain proper prior authorization if the member requires a service for which prior authorization is required
- Work with the PCP to ensure that the referral or prior authorization process is completed correctly

PREVENTIVE CARE SERVICES

Trillium expects practitioners to provide preventive care promoting physical, oral, and behavioral health. Preventive services include, but are not limited to, periodic medical examinations and screening tests

based on age, gender, and other risk factors; screenings; immunizations; and counseling regarding behavioral risk factors. For children up to age 21, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services include medically necessary and medically appropriate services to treat any physical, dental, vision, developmental, nutritional, mental, and behavioral health condition. Trillium requires practitioners to report services rendered to members, and practitioners are subject to Trillium's Medical Case Management and Record Keeping policies.

Access to Care

Providers agree to accept all new Trillium members. If a provider elects to close their practice to all new Trillium members, the provider may do so after giving Trillium 45 days' notice of such closure. Subject to the first sentence of this paragraph, a provider may close their practice to new Medicaid members if the provider's practice is closed to all new Medicaid patients. Trillium may assist, upon the provider's request, in the transfer of members to another participating provider if the provider determines that quality medical care could not be maintained with such members.

Trillium is committed to providing equal access to quality healthcare and services that are physically and programmatically accessible for members living with disabilities. Trillium provides a choice of providers (including physical health, behavioral health, providers treating substance use disorders, and oral health) who are able to provide Culturally and Linguistically Appropriate Services within the Delivery System Network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations. All participating Trillium providers must comply with the requirements of the Americans with Disabilities Act and the appropriate Availability of Service rules for the Oregon Health Plan. This means that providers must provide physical access, reasonable accommodations, and accessible equipment for Trillium members with physical or mental disabilities. Providers must have provisions for patients with visual and/or hearing impairments and have procedures for using translation services for members who require them – or for utilizing Trillium's translation service.

Trillium provides telemedicine services for general medicine, dermatology, smoking cessation, and behavioral health. Trillium also offers its members a 24-hour Nurse Advice Line to triage appropriate utilization of emergent and urgent services. See Culturally and Linguistically Appropriate Services, Interpreter Services, Members with Hearing Impairment, and Translation and Alternate Formats of Documents Services for further information.

ACCESSIBILITY OF PROVIDERS

Trillium requires providers to follow the appointment accessibility standards of the Oregon Health Plan, the Oregon Administrative Rules (OARs), and applicable accrediting agencies. Trillium monitors compliance with the appointment accessibility standards on an annual basis and uses the results of appointment standards monitoring to achieve adequate appointment availability and reduce unnecessary emergency room utilization. Appointments for members for covered health and behavioral health services shall be within a time period appropriate for their individual condition. All providers must offer hours of operation that are no less than the hours of operation offered to commercial and other plan patients.

Providers shall make Covered Services available 24 hours a day, seven (7) days a week. Providers are required to prioritize timely access for members with Special Health Care Needs (SHCN) and Prioritized Populations:

- Pregnant women, IV drug users, and Veterans and their family's immediate assessment and intake
- Members with opioid use disorders assessment and intake within 72 hours
- Members requiring medication-assisted treatment assessment and induction no more than 72 hours after request
- SHCN members, including those with complex case management, multiple chronic conditions, mental illness, or recognized substance use disorders, are able to access routine care appointments within 21 days of a request. For all other members, providers must make appointments as follows:

PHYSICAL HEALTH APPOINTMENT ACCESS STANDARDS

Appointment Type	Appointment Standard
Routine/regular care appointment	Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OAR 410-141-3860 through 410-141-3870
Emergency care	Immediate, or referred to an emergency room based on the member's condition
Urgent care	Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840
After-hours	A patient's after-hours call must be received by one of the following: • By medical staff directly • By an answering service that could reach an on-call provider • By a recorded or automated message that has both emergency instructions and a way to reach medical staff

BEHAVIORAL HEALTH APPOINTMENT ACCESS STANDARDS (NON-PRIORITIZED POPULATIONS)

Appointment Type	Appointment Standard
Urgent care	24 hours
Initial visit for routine care	Intake assessment within 7 days of the request with a second appointment occurring as clinically appropriate

SPECIALTY BEHAVIORAL HEALTHCARE APPOINTMENT ACCESS STANDARDS

Prioritized Population	Appointment Standard
For specialty behavioral healthcare for priority populations, the member is seen, treated, or referred within the following time frames: Note: If a time frame cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessment or other services described in OAR 309-019-0135.	
Pregnant women, veterans and their families, women with children, unpaidcaregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the intellectual/developmental disability(I/DD) population	Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist.
IV drug users including heroin	Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist.
Opioid use disorder	Assessment and entry within 72 hours.
Medication assisted treatment	As quickly as possible, not to exceed 72 hours for assessment and entry.

Children with serious emotional disturbance as defined in 410-141-3500 (65). Subpopulation of individuals under age 21 who meet the following criteria: A child or youth, between the ages of birth to 21 years of age; and (b) Must meet criteria for diagnosis, functional impairment and duration: (A) Diagnosis: The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder): (i) For children 3 years of age or younger. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised (DC: 0-3R) (or subsequent revisions); (ii) For children 4 years of age and older. The child or youth must have an emotional, socio-emotional, behavioral or mental disorder diagnosable under the Diagnostic Interview Schedule for Children (DISC) or DSM-5 or its ICD-10-CM equivalents, or subsequent revisions (with the exception of DSM "V" codes, substance use disorders and developmental disorders, unless they co-occur with another diagnosable serious emotional, behavioral, or mental disorder). (B) Functional impairment: An individual is unable to function in the family, school or community, or in a combination of these settings; or the level of functioning is such that the individual requires multi-agency intervention involving two or more community service agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care; (C) Duration: The identified disorder and functional impairment must have been present for at least 1 year or, on the basis of diagnosis, severity or multi-agency intervention, is expected to last more than 1 year. (this is pulled straight from OAR 410-141-3500)	Immediate assessment and entry.

DENTAL CARE APPOINTMENT STANDARDS

Appointment Type	Appointment Standard
Pregnant individuals:	
Routine/regular care appointment	Within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) weeks appropriate.
Dental emergency services (for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth)	Seen or treated within 24 hours.
Urgent care	Within one (1) week.
Children and non-pregnant individuals:	
Routine/regular care appointment	Within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks as appropriate.
Dental emergency services (for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth)	Seen or treated within 24 hours.
Urgent care	Within two (2) weeks

*These access standards were updated December 2025.

A member may request to reschedule an appointment if the wait time for a scheduled appointment exceeds 30 minutes. If the member requests to reschedule, they shall not be penalized for failing to keep the appointment. Trillium requests that providers inform our Member Services Department when a member misses an appointment, so we may monitor and provide outreach to the member on the importance of keeping appointments.

Trillium asks its providers to adhere to the Oregon Administrative Rules (OARs) for Network Adequacy: OAR 410-141-3515

AFTER HOURS

Participating providers agree to provide 7-days-a-week, 24-hour per day coverage for all members.

The selected method of 24-hour coverage chosen by the provider must connect the member or caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

As required by Trillium's contract with the Oregon Health Authority (OHA), and in order to advance health equity, improve quality, and help eliminate healthcare disparities in the communities we serve, Trillium uses the National Culturally and Linguistically Appropriate Services (CLAS) Standards as a foundation to implement culturally and linguistically appropriate services. Adoption of these Standards helps advance better health and healthcare in not only our communities, but the United States. Services provided by Trillium and Trillium's provider network must be in an accessible and responsive manner to all members including those with diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency, disabilities, and different abilities regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.

To meet these requirements, if a member has limited English proficiency (LEP), is non-English speaking, has a hearing impairment, or requests an interpreter, providers must offer or arrange Health

Care Interpreter (HCI) and translation services for the member. This applies to all provider types, including physical, behavioral health, dental, and non-emergent transportation providers.

INTERPRETER SERVICES

HCI services for members must meet the following requirements:

- Interpreters are available at no cost to members at the time of the appointment and during and after hours for consultation and provision of care.
- Member's language needs, requests for, and refusal of interpreter services must be documented in the member's medical record.
- Extend the same program and activity to all members regardless of language preference.
- Services provided to LEP members are as effective as those provided to non-LEP members.
- Family members or friends acting as an interpreter or translator for the patient is not appropriate since these persons are not usually familiar with medical terms, and interpretation or translation errors may be made, or information be incorrectly communicated, overlooked, or withheld.

To arrange for HCI services, follow at least one of the options below:

1) Use bilingual providers if the provider or office attested to proficiency in the needed language during the credentialing process with Trillium.
2) Use staff who are certified or qualified by OHA to provide interpretation services.
3) If staff are not OHA certified or qualified, use staff who are otherwise certified or qualified to provide HCI services, per State and Federal requirements.
4) Untrained staff who are not qualified or certified interpreters should not be used for HCI services.
5) Contact Trillium Provider Services at 877-600-5472 and we will ensure arrangements are made for HCI services.
6) Use Trillium's approved interpretation subcontractors. If HCI services are needed on short notice, providers may call Trillium's interpretation subcontractors directly. No access code is required for these services. Inform the subcontractor you are calling to arrange for services for a Trillium Community Health Plan member. Both subcontractors provide on-site, telephonic, and video interpretation services. Video interpretation services include on-demand video remote (VRI) as well as Scheduled Video Interpreters/ telehealth (SVI). Contact either:
    - Linguava Interpreters at 503-265-8515
    - Passport to Languages:
        - Southwest Region (Lane County and surrounding area): 800-297-2707
        - Tri-County Region (Clackamas, Multnomah, and Washington Counties and surrounding area): 503-297-2707

When arranging interpreter services, please make the request as far in advance as possible, at least one business day, especially if there is a need for the interpreter to be physically present on-site at the visit or present via telehealth platforms. If advance notice is not possible, a telephone or remote video interpreter may be arranged by contacting the subcontracted interpreter services listed above.

Trillium will pay for HCI services provided for Medicaid covered services. If the service is provided by qualified or certified staff, providers may bill Trillium by adding HCPC code T1013 to the claim. If the service is provided by Linguava or Passport, the subcontractors bill Trillium for the service.

Members with Hearing Impairment

Providers should be prepared to meet the needs of the hearing impaired.

To arrange for an American Sign Language interpreter to be present at an appointment, contact Trillium Provider Services at 877-600-5472 at least one working day before the appointment.

For urgently needed sign language interpreter services, call:

- Linguava Interpreters at 503-265-8515

- Passport to Languages:
    - Southwest Region (Lane County and surrounding area): 800-297-2707
    - Tri-County Region (Clackamas, Multnomah, and Washington Counties and surrounding area): 503-297-2707

If you do not have the ability to meet the needs of a patient/member with hearing impairment, please contact Member Services at 877-600-5472 and we will ensure that arrangements are made for care that will meet the member's needs.

The Oregon Telecommunications Relay Service is available at 800-735-2900 to facilitate phone communication with members utilizing special telecommunications devices.

Translation and Alternate Formats of Documents Services

To meet ADA, Section 1557 of the ACA, and CLAS requirements, providers must offer translation or alternate formats such as large print or braille of documents and materials used by their office at no cost to the member.

Providers are not reimbursed for costs related to translation and alternate formats of documents.

Practices on Emergency & Urgent Care Services

EMERGENCY CARE SERVICES

Members are instructed in the Trillium Member Handbook to call their PCP whenever they need healthcare. If a member calls and information is adequate to determine that the call may be emergent in nature, the practitioner must respond immediately by phone. If a member believes they have an emergency medical condition, they are instructed to call 911 or go to the emergency room.

OUT-OF-AREA EMERGENCY SERVICES

Trillium members who need services that cannot wait until they return home may refer to the member handbook for instructions. Members should make sure they have their Trillium ID card with them when they travel out of state; present their card as soon as they can and ask if the provider is willing to bill Trillium (Medicaid); contact Trillium and discuss the situation and ask for advice on what to do; not sign any paperwork until they know the provider is willing to bill Trillium (Medicaid); and if at all possible, have Trillium speak with the provider's office while they are there. Members are also advised to contact their PCP for follow-up and/or transfer of care. Ambulance services are covered in case of emergencies. If a member uses an ambulance for something that the member believes is not an emergency, the member may have to pay the bill.

When the PCP is notified of an out-of-area emergency which requires follow-up or has resulted in an inpatient admission, the PCP is expected to monitor the member's condition, arrange for appropriate care, and determine whether the member may be safely transferred to a participating hospital in coordination with Trillium's Care Coordination team.

UTILIZATION OF EMERGENCY SERVICES

Some Trillium members may use the emergency room to obtain routine care that could be provided in the practitioner's office or in a lower cost outpatient setting. Trillium encourages all providers to discuss the appropriate utilization of urgent and emergent services with their patients. Trillium offers a 24-hour, 7 days a week Nurse Advice Line at 844-674-9667 as well as telemedicine through Teladoc for Behavioral Health, Dermatology, and General Medicine at 855-782-8548 (option 1). Notify Trillium's Provider Services at 877-600-5472 who will work with the member's caseworker, the practitioner, and other agencies as necessary and appropriate.

Access to Records

As part of our contract, providers must maintain, provide access to, and retain member medical and financial records. For medical records, the contract requires providers to maintain a single standard medical record for the member's medical care to confirm that your records meet professional standards. Providers must maintain financial records of member payments and payments from others on behalf of the member in accordance with generally accepted accounting principles and state and federal law. Various government agencies, including but not limited to the Oregon Health Authority, Oregon Division of Medical Assistance Programs, Oregon Addictions and Mental Health Division and the Centers for Medicaid and Medicare Services require Trillium to provide access to records for their oversight purposes. The contract contains timelines for providing Trillium access.

For record retention, retain your records for 10 years, but if an audit, litigation, or other action involving the records is initiated within the 10-year period, keep the records until the matter is resolved or 10 years, whichever is longer.

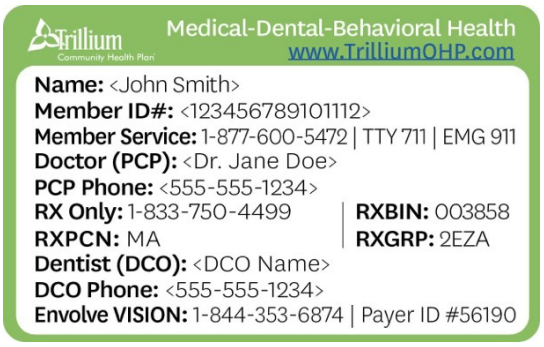
Trillium Members

MEMBER IDENTIFICATION

Members are instructed to bring their Member Identification Card with them to each medical visit. We recommend that you check the member's Identification Card at each visit. It is recommended that a copy of the member's card be kept for your records.

Tri-County

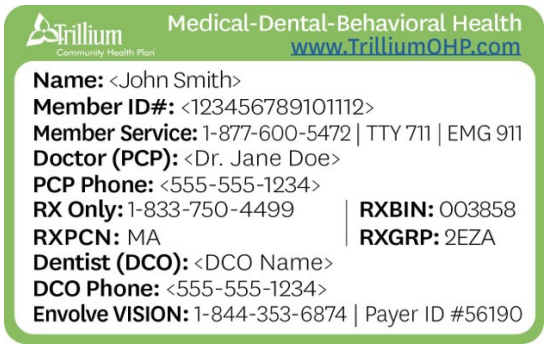
Front



Back

Lane County

Front



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MEMBER VERIFICATION

Member eligibility can be verified by checking the Trillium Provider Portal. It is available 24 hours a day, 7 days a week, except during regularly scheduled down time on the weekend. Patients' coverage may also be verified by calling Provider Services at 877-600-5472 or accessing the State of Oregon's Provider Web Portal.

Eligibility may also be verified using the state's Automated Voice Response (AVR) at 866-692-3864.

Information regarding the State of Oregon's provider services may be accessed by contacting the Division of Medical Assistance Programs (DMAP) at 800-336-6016 or dmap.providerservices@dhsoha.state.or.us.

Additional contact information is available from the Oregon Health Authority

Should a Trillium member who is not currently assigned a PCP present themselves for treatment, please contact Provider Services at 877-600-5472 for a PCP assignment to your clinic.

PCP Assignment Procedures

PRIMARY CARE PROVIDER SELECTION

Members are required to choose a Primary Care Physician (PCP) at the time of enrollment. A PCP may be a Trillium participating provider in one of the following specialties:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Naturopaths
- OB/GYN (if the practitioner requests Trillium to make the practitioner available for designation as a primary care provider)
    - Trillium provides female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive healthcare services. This is in addition to the female member's designated source of primary care if that source is not a women's health specialist.

Each individual family member may choose the same family PCP or a different PCP. Each member will have their own Member Identification Card with the member's PCP listed. Trillium members who do not select a PCP will have one assigned to them by Trillium.

SCHEDULING MEMBER APPOINTMENTS & CHANGES

Practitioner-Initiated Appointment Changes:

In the event it becomes necessary to reschedule an existing appointment with a patient for any reason, provider staff will call the impacted patient. Attempts will be made to have those patients with urgent medical needs seen by a call-share partner at the time of the existing appointment or reschedule a visit within one (1) working day.

Member Benefits

SUMMARY OF MEMBER BENEFITS

Benefits provided to Trillium members are based on the Prioritized List of Health Services.

To obtain a current listing of the Prioritized List, visit:
oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List

EPSDT services are exempt from denial based on the Prioritized List and must be medically reviewed (Ex B, Pt 2, Sec 13, A, 7).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, in accordance with 42 CFR § 441 Subpart B, offers comprehensive and preventive healthcare services for eligible clients under age 21. This child health program assures the availability and accessibility of required medically necessary and medically appropriate services to treat any physical, dental, vision, developmental, nutritional, mental, and behavioral health condition.

Covered condition/treatment pairs for medical services are defined by specific ICD-10-CM procedure codes and CPT procedure codes. For behavioral health codes, use DSM-IV and the Mental Health and Developmental Services Division Medicaid Procedure Codes. For dental services, use the American Dental Association Codes (CDT-2).

The Basic Healthcare Package provided by the Oregon Health Plan, administered by Trillium, includes:

- Behavioral health treatment and substance use treatment services
- Diagnosis and screening for all conditions on the Prioritized List, even those for which treatment may not be covered
- Family planning services, including IUD insertion, birth control pills, over-the-counter
- contraception, permanent sterilization, emergency contraception (See Formulary or Look-Up Tool)
- Hospice care
- Hospital services
- Medically necessary transportation
- Most organ transplants
- Prescription drugs and ancillary services, such as durable medical equipment
- Primary care services, routine physicals, mammograms, obstetrical care, immunizations, smoking cessation programs and well-child exams
- Second opinions at no cost to the member
- Out-of-network referrals require authorization.
- When a Trillium enrollee requires a referral for out-of-network, Trillium will coordinate payment with out-of-network providers to ensure the cost to the member is no greater than it would be if services were provided within the network for as long as Trillium's provider network is unable to provide the services.
- Specialist services
- Vision care for pregnant women and members under 20 years of age

NON-FUNDED TREATMENT (CPT CODE)/ CONDITION (ICD-10-CM CODE) PAIRS

Understanding the nature of the treatment/condition pairs that fall below the funded line is important.

Please keep these principles in mind:

- Treatment/condition pairs are defined by specific CPT procedure codes and ICD-10-CM diagnosis codes. Claims, referrals, and prior authorization requests must have accurate CPT and ICD-10-CM codes in order to determine coverage. ICD-10-CM codes must be used to the greatest degree of specificity.

- The presence or absence of a comorbid condition may affect coverage. If you are aware of a
- comorbid condition, provide that information with requests for referral or prior authorization of services.
- Diagnostic services are covered until a diagnosis is reached.
- Services for non-funded treatment/condition pairs may be provided at the member's expense; however, arrangements for payment must have been made prior to the provision of treatment.

In the case of non-covered treatment/condition pairs, you must ensure that your patient is informed of:

- Clinically appropriate treatment that may exist for the patient's condition, whether covered or not
- Community resources that may be willing to provide non-covered services
- Future health indicators that may warrant a repeat diagnostic visit

Health-Related Services: Flexible Services

What are Health-Related Services (HRS)?

They are non-covered services intended to improve care delivery and overall member and community health and wellbeing. Flexible Services are items and services that are non-covered by other benefits at an individual member level to support them in their goals to success through their treatment/care plan.

Types of Flexible Services

Flexible services include critical repairs, tablets for telehealth, temporary housing, transportation, gas cards, air purifiers, meal delivery, grab bars, weight scales, bicycle repairs, athletic shoes, and many other items that are components used in achieving success of the member's treatment plan.

Who can make a request?

A current Trillium member or a member of their primary care team can make a request.

How to make a request –

- Call Trillium at 1-877-600-5472 (TTY: 711) and ask for Care Management or Member Connections. They will complete the form and coordinate with the care team for supporting information.
- Email CHW@TrilliumCHP.com
- Fax 1-877-703-0958

The request form is located on the Trillium member website. The form is completed by the

member's provider and/or care team. When the member makes the request directly from Trillium, a Trillium Care Manager or Member Connections team member completes the form with/for the member.

Process Review

- Trillium checks eligibility with the plan and ensures the request meets the requirements.
  - Item/service meets the following:
  - Improves health quality
  - Increases likelihood of desired health outcome in a manner that is measured / produces verifiable results/achievements
  - Item/service is specifically for this member
- Based on any of the following:
  - Evidenced-based medicine
  - Widely accepted best clinical practice
  - Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national healthcare quality organizations.
- Achieves at least one of the following:

- Improves health outcomes compared to a baseline and reduces health disparities in specified populations
- Prevents avoidable hospital readmissions through comprehensive program for hospital d/c
- Improves patient safety, reduces medical errors, lowers infection and mortality rates
- Implements, promotes, and increases wellness and health

Determination

- Approved, member is notified and the item/service is coordinated.
- Not Approved, member is notified, and they have the right to submit a grievance if they disagree with the finding.

Questions and requests for additional information on flexible services may be sent through CHW@TrilliumCHP.com or by calling 877-600-5472 (TTY: 711) and asking to speak with a Member Connections Representative.

NEMT (Non-emergent medical transportation)

Trillium provides access to safe, timely, and appropriate NEMT services for all members enrolled in a Trillium OHP plan. NEMT services include transportation to OHP-covered services.

NEMT services are exclusive of emergency transports. Call 911 if the member needs an emergency transport.

A Medical Ride Guide is available on our website that provides additional information on NEMT services.

TRANSPORTATION TYPES

- Mileage, meal, and lodging reimbursement
- Bus pass
- Taxi
- Wheelchair accessible van/bus
- Stretcher car
- Secure transport (involuntary transport of members in danger of harming themselves or others)

SERVICE TYPES

If requested, drivers can:

- Help the member walk up or down one or two steps
- Help the member go to and from a door to the vehicle
- Help the member into the lobby of the healthcare facility

WHAT RIDES ARE COVERED

- Rides to and from OHP covered services, including medical, dental, and mental health
- Members eligible with the Compact of Free Association (COFA) Dental
- Program or the Veteran Dental Program are only eligible for rides to a dental service.
- Rides for pharmacy services
- Rides to and from select Health-Related Services, with prior approval from Trillium

PROVIDERS AND NEMT

Providers may:

- Request rides for members
- Submit grievances related to NEMT
- Submit care coordination referrals for members who may have transportation barriers

Trillium or its NEMT brokerages may contact providers:

- When a member's ride request is denied: Oregon rules require a copy of the denial letter for a denied trip request be sent to the in-network provider the member was scheduled to see.
- For information on a member's mobility to assess appropriate type of transport
- When a brokerage needs to verify an appointment: Brokerages conduct appointment verification for non-urgent, same-day appointments and for a percentage of rides.
- Members are required to obtain a signature from their provider's office in a trip log for mileage reimbursement and submit to the NEMT brokerage within 45 days of the ride.

HOW TO REQUEST A RIDE FOR A MEMBER

Providers are not required to request a ride for a member. It is the member's responsibility to request a ride if they need one. However, providers, member representatives, Community Health Workers, foster parents, and adoptive parents may request a ride for a member. The member can find more information on NEMT services in their member handbook and by calling Trillium or the transportation number on the back of their ID card.

Trillium contracts with a different brokerage for each of our service regions. Contact the brokerage serving the county in which the member lives, even if the trip is for outside that county.

To request a ride for a member:

- Contact the appropriate NEMT brokerage as far in advance as possible of the member's appointment (at least 24 hours).
- If necessary, rides can be scheduled the same day as the appointment, but we cannot guarantee the member will make it to the appointment on time if the ride is not
- requested soon enough.
- A ride can be scheduled up to 90 days before the appointment.
- Transportation is provided any time, every day of the year by calling the NEMT brokerage to schedule a ride.
- If there are multiple appointments, the rides can be scheduled at one time

The following information is required in order to schedule a ride for a member:

- The member's name, address, phone number (any clear directions to the home or location of pickup), OHP or Trillium ID, or other information to confirm the member's Trillium eligibility
- Doctor name or Facility
- Doctor or Facility address and phone number
- Referring doctor, if appointment is outside of the service area
- Date and time of the appointment
- Drivers cannot schedule to pick members up more than 15 minutes before the office opens unless requested when the ride is scheduled.
- Pick-up time after the appointment
- Drivers cannot schedule to pick up members more than 15 minutes after the healthcare provider's office closes unless the appointment is not reasonably expected to end by that time or you request it.
- Type of appointment (primary doctor, therapy, behavioral health, etc.) to confirm the appointment is for an OHP-covered service
- If someone will be traveling with the member
- Members 12 years of age and younger or who need help traveling on their own require an attendant to travel with them to and from appointments.
- Any mobility needs (such as a wheelchair or service animal), and other information necessary to help the brokerage determine the appropriate type of transport for the member

- Your office may be contacted about the member's mobility to help the brokerage determine the most appropriate transport mode (taxi, wheelchair van, stretcher van). The brokerage will document this information in their system and reference it for future trips.
- Details on the mobility device being used (such as the width of a wheelchair) to confirm if a specialty vehicle will be needed for transport.
- Any special information to help set up the ride to meet the member's needs (such as car seats, children)

Return trip rides: Please be sure to schedule the return trip ride at the same time as the scheduled ride to the appointment. If it is unclear when the appointment will end, let the brokerage know and they will schedule a will-call pick-up for the member. Once the appointment is over, the member or the provider will need to call the brokerage and a driver will be there to pick the member up within one hour.

MILEAGE, MEALS, AND LODGING REIMBURSEMENT

If the member has use of a car, they can receive help with the travel costs. Funds can be paid to the member, a caregiver, family member, or friend for travel costs. If the member must travel outside of the area for healthcare services, they may be able to get help with costs for meals and lodging. Meal help is not available if the member is inpatient (admitted to a hospital or facility), or when meals are available to the member at no cost. Trips must be scheduled with the brokerage in advance in order to be eligible for reimbursement.

When you request a ride for the member, if mileage reimbursement or a bus pass is the appropriate transport mode, the brokerage will follow up with the member to ensure they receive the necessaryforms or passes. Reimbursement requires the member to log their trip information, obtain a signature from their provider office, and submit the completed form to the brokerage within 45 days of the appointment.

DENIAL OF RIDES

If the ride is denied, based on the program rules and according to OHP rules, Trillium gives the member a verbal denial. Trillium also sends the member a letter that gives the rule and reason for the denial. A copy of this letter will be sent to the doctor if the ride was to a scheduled appointment. The member can appeal the denial with Trillium Community Health Plan and the instructions for appealing the denial are included with the denial letter. A denied ride does not mean the medical appointment is denied. The member is instructed to call Trillium or confirm with their doctor if they have any questions about whether the medical appointment will be covered.

MEMBER'S PRIVACY

NEMT brokerages comply with legal standards to keep protected information safe.

Medical information is only provided to drivers when needed (for example, the member uses oxygen). Drivers will not share any information outside of the ride except with the brokerage, Trillium, the Oregon Health Authority, or the Oregon Department of Human Services, as required or requested.

EXPECTATIONS OF DRIVERS

Drivers should:

- Hold the member's safety as their highest priority
- Be friendly, courteous, and professional
- Treat the member and providers with respect and dignity
- Drive safely and follow all laws and regulations
- Use hands-free device for phones and tablets
- Have completed all State required training (such as CPR, First Aid, and Defensive Driving)
- Drop members off at least 15 minutes before scheduled appointments

Drivers cannot:

- Walk the member beyond the lobby of the healthcare facility. The member will need to provide their own attendant to help them.
- Enter the member's home or room (except for a hospital discharge or a stretcher car transport)
- Help the member get ready for transport (dressing, and so on)
- Transfer the member between bed and wheelchair, or wheelchair and van
- Help the member with any personal needs during the ride
- Ask for or accept fares or tips
- Solicit or sell any other products or services
- Make any stops or run errands

CONTACT INFORMATION AND SERVICE HOURS

Trillium is contracted with a brokerage for each region we serve. When requesting a ride for a member, contact the brokerage serving the county in which the member lives, even if the trip is for outside that county.

Eugene Region: Lane, Western Douglas, Western Linn Counties
(541) 682-5566 or (877) 800-9899 (TTY: 711)
Hours of Operation - Monday through Friday, 8:00 am – 5:00 pm, 24/7 for urgent rides or after leaving the hospital.

Portland Region: Clackamas, Multnomah, Washington Counties
(877) 583-1552 (TTY: 711)
Hours of Operation - Sunday through Saturday, 8:00 am – 5:00 pm24/7 for urgent rides or after leaving the hospital.

Phamacy Program

Trillium's goal is to offer the right drug coverage to our members. We work with doctors and pharmacists to make sure we offer drugs used to treat many conditions and illnesses. Trillium covers prescription and some over-the-counter drugs when they are ordered by a licensed prescriber. The pharmacy program does not cover all drugs. Some drugs need our prior approval. Some have a limit on the amount of drug that can be given. Trillium's Preferred Drug List is available under Provider Resources on our web page.

Enrolled providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A.655 before prescribing a schedule II controlled substance pursuant to 42 U.S.C 1396w-3a. The PDMP check does not apply to clients in exempt populations.

Membership Policies

As Oregon Health Plan participants, Trillium members have certain rights and responsibilities pertaining to their healthcare. You will find all member handbooks on the Trillium member website. As our members' healthcare partner, we make sure their rights are guarded while providing their healthcare benefits. This includes access to Trillium's network providers and providing members information to make the best decisions for their health and welfare. We also honor our members' right to privacy and to receive care with respect and dignity and free from any form of restraint or seclusion used as a means of coercion, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion. Providers that may use restraints and seclusion are required to share their restraints and seclusion policies with Trillium and report when restraints and seclusions are used on a Trillium member.

Members do not need to get a prior approval or a referral from a Primary Care Physician in order to gain access to behavioral health assessment and evaluation services. Also, members may refer themselves to behavioral health services available from Trillium's provider network and have the right to refer themselves to a Traditional Health Worker for covered services.

For children and others unable to make their own medical care choices, a legal guardian or agent has responsibility for ensuring member rights on their behalf.

Members have the right to access their own personal health information so the member can share the information with others involved in the member's care and make better healthcare and lifestyle choices. Members reserve the right to receive information on treatment options and alternatives and the right to request that medical records be amended and corrected. Providers may charge members for reasonable duplication costs when they request copies of their records.

Members have the ability to exercise their rights, and the exercise of those rights does not adversely affect the way the Trillium, its staff, subcontractors, participating providers, or OHA treat the member.

Trillium shall not discriminate in any way against members when those members exercise their rights under the OHP. All eligible members have the right to participate or decline participation.

Subcontractors shall ensure that each member is free to exercise their rights, and that the exercise of those rights does not adversely affect the way the Contractor, its staff, Subcontractors, Participating Providers, or OHA treat the member.

Trillium's OHP Member Rights & Responsibilities are detailed on the Member Rights page of the Trillium website.

Member Medical Care Release Policies

In the case of a threat or act of physical violence, or a fraudulent or illegal act, a provider may contact Trillium at 877-600-5472 and request release of a member from medical care. The verbal request must be followed by a written request, which includes documentation of the circumstances surrounding the request.

The provider shall notify the member of the intent to release from medical care in writing, by certified mail, 30 days in advance. The letter must specify the reasons for the dismissal. The provider must send a copy of the letter to Trillium.

During the 30-day period between notification and release, the provider remains responsible to provide acute, urgent, or emergent care to the member.

Providers should make every effort to resolve problems with members. Providers may inform members that their behavior may result in termination of medical care. Document all efforts to resolve the situation, including the options presented to the member and evidence that the member's response was considered. Members shall be allowed, at a minimum, three (3) missed appointments before the provider may request that the member choose or be reassigned to another PCP.

Trillium may assist providers in resolving issues with members. An Exceptional Needs Care Coordinator may contact and involve the member's caseworker, the member, and other appropriate staff and agencies in the resolution.

Trillium may develop a plan of care with the caseworker that details the problem, how it will be addressed, and arrange for a case conference with appropriate staff, agencies, practitioners, etc., as needed.

Reproductive Specialty Services

HYSTERECTOMIES AND STERILIZATIONS

Hysterectomy and sterilization policies are found in OAR 410-130-0580.

Please review the rules and regulations that apply to hysterectomies and sterilization. Consent must be informed, and the proper forms filled out precisely to avoid the denial of a claim. The required forms vary depending upon the procedure and the age of the person seeking the procedure. Each form must be signed and dated in a particular order and within a particular time frame in relation to the procedure.

The OHA Medical-Surgical Services Program assists in the process of garnering consent properly and completing the forms correctly. This is a federally funded program that offers no leeway for claims and forms that are incomplete, filled out incorrectly, or illegible.

All claims submitted, for sterilization-related services, must have a copy of the correctly completed consent form attached to each claim. If a correctly completed consent form is not attached, all sterilization-related services will be denied (hospital, anesthesiology, pathology, etc.).

HYSTERECTOMY AND STERILIZATION CONSENT FORMS

Hysterectomy and Sterilization Consent forms (DMAP forms 741, 742A and 742B) for Trillium members may be obtained from: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Medical-Surgical.aspx

Billing and Claims Payment

BILLING

For most billing and claims payment questions, the Trillium OHP Billing Manual on our Provider Resources page is the most efficient and convenient provider resource for accessing claims information.

For answers and claims information not found in the OHP Billing Manual, contact Member Services by phone at 877-600-5472. Mail OHP Claims to:

Trillium Community Health Plan
ATTN: CLAIMS
P.O. Box 5030
Farmington, MO 63640-5030

Smoking Cessation Services

Trillium members are eligible for the Quit for LifeTM Program co-sponsored by the American Cancer Society.

To enroll, members may call the Quit Line at: 866-784-8454, or visit https://www.quitnow.net.

Fraud and Abuse

Trillium requires a provider to report when it has received an overpayment, to return the overpayment to Trillium within 60 calendar days after the date on which the overpayment was identified, and to notify Trillium in writing of the reason for the overpayment.

Trillium Community Health Plan
ATTN: CLAIMS
P.O. Box 894290
Los Angeles, CA 90189-4290

Trillium has the right to pursue recovery of any overpayments made by Trillium to providers. Trillium audits any investigations that result in findings of overpayment to a provider.

The provider shall promptly refer all suspected fraud and abuse, including fraud or abuse by its employees, to Trillium. These can be reported to Trillium's Fraud, Waste, and Abuse Hotline at 1-866-685-8664 or by email at ComplianceOregon@Centene.com

Providers and their fiscal agents shall 1) disclose ownership and control information and 2) disclose information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, CHIP, or the Title XX services program. Such disclosure and reporting is made a part of the provider enrollment agreement, and the provider shall update that information with an amended provider enrollment agreement if any of the information materially changes. The Authority or Department shall use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule shall be construed in a manner that is consistent with the Authority or Department acting in compliance with those federal requirements.

Affirmative Statement about Incentives

Trillium does not reward providers for issuing denials of coverage or to encourage barriers to care. Utilization Management decision making is based only on appropriateness of care and service and existence of coverage.

Coordinated Care

POPULATION HEALTH

The mission of Population Health is to enhance member health and deliver quality, cost-effective healthcare services through collaboration with members, providers, and the community.

The program's scope encompasses all healthcare delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities (SNF), home care services, DMEPOS, outpatient care, intensive outpatient programs, partial hospital facilities, behavioral health services, and levels of care coordinated like respite, residential and detox, and office visits.

POPULATION HEALTH CUSTOMER SUPPORT TEAMS

The Utilization Management, Pharmacy, and Case Management teams are available for providers to contact directly for all questions relating to the Trillium Population Health Department. This includes questions on pharmacy, utilization management, care coordination, patient transitions, community care services referrals, care plans, and other inquiries. Providers can also contact the Case Management team when they need to reach someone specifically from the member's care team.

To access Trillium's Utilization Management, Pharmacy, or Case Management teams, providers and their staff may call Provider Services at 877-600-5472 and select the appropriate transfer option. Providers may also securely send questions via the provider portal or via case management referral email.

The Utilization Management team facilitates (or reviews) the benefits available to the member under the appropriate rules. The focus is on determining whether a service constitutes a covered benefit, whether criteria for coverage have been met, and whether the service is the most cost-effective option among those available. Clinical Specialists with appropriate licensure typically perform this function.

CARE COORDINATION

Trillium's Care Coordination program focuses on using all appropriate benefits and supplementing them with community resources to help members overcome barriers to health and reach the goals of their

personal care plan. Case managers and/or care coordinators identify, and then facilitate improvement in, an individual member's health status related to conditions such as tobacco use, Type 2 diabetes, and chronic lung disease. Issues of fragility, health literacy, social isolation, social determinants of health, and related psychosocial issues that may impact health conditions and healthcare are assessed for impact on the member and the member's ability to engage in managing their health.

Health Risk Screening (HRS) Assessments are available for members to complete online, on paper, or telephonically. The information gathered from the HRS is used to develop a member-centric care plan and identify potential programs from which the member might benefit.

Trillium uses an interdisciplinary care team approach to meet the diverse needs of our membership by including appropriate healthcare partners and social service agencies, including parties that the member feels are appropriate to be included in their care team. This improves the development of care plan for the member to assure their physical, oral, and behavioral health needs are met. Care coordination services are available to all members on any Trillium health plan. Providers can directly refer members to our care coordination program by phone or through the provider portal.

The care coordination team also provides intensive care coordination services teams for members on the Oregon Health Plan. This program helps members who have complex, exceptional, or special needs, such as members aged 65 or over, disabled members of any age, and members with additional needs such as special equipment or support services. These services are for more complex cases, which help support the member's acute needs, as well as long-term goals to ensure members' needs are supported.

The care coordination team may be able to assist you with members whose behavior affects their ability to receive care (disruptive behaviors, health literacy, and other issues). Because of the challenging nature of interacting with some members, several types of care coordinators may be involved in a member's care at any given time and, as a team, work both collaboratively and proactively with the member and the medical home.

The Trillium Member Handbook describes the Care Coordination program and advises members to contact Trillium if they believe they need services.

CARE TRANSITIONS

Members experiencing either a planned or unplanned hospital admission are followed closely by telephone after discharge to minimize:

- CCO (or other health plan) transition to Trillium
- Disconnection from their medical home
- ED visits
- Re-hospitalization, or
- Other common problems associated with care transitions

CONCURRENT REVIEW

The Trillium Concurrent Review team, which is comprised of clinical specialists, conducts concurrent reviews for the purpose of assisting facility discharge planners and reducing adverse events associated with transitions between care settings. Those aspects of utilization management take place during an inpatient or facility stay when the member will be experiencing a transition to another location for ongoing care. The Concurrent Review team reviews current residential facility, hospital inpatient, and hospital outpatient census reports on a daily basis. This team of nurses communicates with the discharge planner, as appropriate, based on the severity or complexity of the member's condition and/or necessary treatment.

The Concurrent Review team, with assistance from the Utilization Management team, processes concurrent authorizations for SNF stays for members, psychiatric inpatient, subacute, and residential. This includes a team approach to coordinate a member's benefits. The interdisciplinary team may also include community partners/agencies, providers, social workers, care coordinators and facilities to

ensure the member receives the appropriate care at the right place. The Trillium Care Coordination program provides transition services, carrying on the work of the Concurrent Review team.

CARE PLANS

Trillium develops care plans within its shared care plan program. Communication and coordination with the PCP and available community resources are central to the development of the care plan and allows the health plan to act as a collaborative partner in the delivery of the scope of services encompassed by the medical home concept. Access to care plans exists via the provider portal, as well as fax or mail. Trillium shares care plans with providers based on needs and changes in the member's needs. Trillium updates care plans with each member interaction and focuses on member-identified goals.

PERINATAL CARE COORDINATION – START SMART FOR YOUR BABY

The Start Smart for Your Baby program promotes education and care management techniques designed to reduce the risk of pregnancy complications, premature delivery, and infant disease, which may result from high-risk pregnancies. The program offers support for pregnant members and their babies through the first year of life by providing educational materials as well as incentives for going to prenatal, postpartum, and well-child visits.

Referrals may be made directly to the perinatal team for pregnant members, but also are triggered off of the notice of pregnancy process.

MEMBER CONNECTIONS REPRESENTATIVES (MCRs)

MCRs (commonly known as Community Health Workers) serve as liaisons between communities, individuals, and CCOs. They are traditional healthcare workers who provide non-clinical health support and social assistance to community residents.

As community health liaisons, MCRs may provide direct services to members in a culturally and linguistically appropriate manner, handling health promotion, as well as assisting with care coordination. They often advocate for individual and community health and are members of the healthcare team serving patients in a variety of ways. These include but are not limited to identifying barriers and needs within the social determinants of health, accessing and locating benefits, navigating care systems, home and community visits, supporting readmission reduction, and coordinating referrals to community agencies. MCRs' responsibilities include connecting members to appropriate community resources, social services, and identifying barriers to care when appropriate. The scope of MCR engagement may either be structured broadly, encompassing multiple patient conditions and communities, or narrowly, where MCR services are targeted to a more focused patient population.

Patients can be referred to work with MCRs and the Care Coordination team. MCRs review and determine the most appropriate level of intervention and engagement. Referral for MCR can be made through calling Provider Services at 877-600-5472 or sending email to CHW@TrilliumCHP.com

Utilization Management

Trillium maintains a specialized provider network that includes primary care, medical and behavioral health specialists, and Durable Medical Equipment (DME) vendors.

Utilization review for planned and/or scheduled service requests is done using the Oregon Administrative Rules (OARs), Prioritized List, CMS NCD or LCD criteria guidelines, Trillium Clinical Policy, Centene Clinical Policy, nationally recognized decision support tools such as Interqual®, and published national evidence-based guidelines such as those from AHRQ and the American College of Radiology's Appropriateness Criteria. Commercial evidence-based resources such as Hayes Review and Up to date are also utilized.

In some cases, direct review of recently published medical literature is performed in order to identify best practices in areas of medicine that are rapidly changing. Trillium's goal is to identify current

standards of care and criteria for establishing medical necessity in order to ensure that all members receive the best possible high-quality care.

Trillium's Clinical and Pharmacy policies can be found on Trillium's website under Provider Resources.

Trillium supplies copies of its Utilization Management criteria to providers upon request. Copies of specific UM criteria can be requested by contacting Provider Services at 877-600-5472. Criteria can be mailed, emailed, faxed, or reviewed over the phone.

Note: Emergency services and urgent medical services are not subject to prior authorization. Requests for reimbursement for these services will be evaluated by review of clinical notes submitted with the claim. Services will be reviewed against the national standards for urgent and emergent services.

COMPLEX CASE MANAGEMENT/INTENSIVE CASE MANAGEMENT

Complex Case Management/Intensive Case Management promotes continuity of care and cost-effectiveness through the integration and functions of case management for Trillium's complex members. Criteria for enrollment into complex management includes an unplanned out-of-area admit, solid organ or bone marrow transplant, VAD, pediatric hematology/oncology, unstable members who meet specific criteria, and select members utilizing high-cost pharmaceuticals. Providers may refer members to Trillium as necessary if the provider believes that complex care management is needed.

PRIOR AUTHORIZATION REQUESTS

The Pre-Authorization (PA) Check Tool on the Trillium Providers webpage indicates if an item or service currently requires prior authorization and allows for efficient submission of required PA requests, including supporting documentation. Please note that the Pre-Authorization Check Tool works in real time; one cannot specify a future date.

When submitting PA requests, include the diagnosis code(s) and all the requested CPT code(s) (or HCPCS codes) as well as documentation to support the request. Make sure the diagnosis ICD-10-CM code is used to the greatest degree of specificity.

For manual submissions, fax the completed request form and all supporting documentation to the number provided on the PA form.

If the request is for hospital services, include the name of the hospital providing services.

While a member will receive notification from Trillium of PA denials, it is the responsibility of the requesting practitioner to notify the patient of an approved authorization. Determination of an authorization is made based on review of Oregon Health Plan coverage first in conjunction with funding per the Prioritized List, and then evaluated for medical appropriateness. Include any information indicating a possible comorbid condition that may affect the decision. Note that the OHP Prioritized List criteria for coverage require condition codes for evaluation of coverage. Symptom codes are not covered for treatment by OHP and will not result in authorization approval if used as the diagnosis component on a PA request.

To request a prior authorization for therapy, a prescription for physical, occupational, or speech therapy must include the diagnosis code(s) and CPT code(s), as well as the recommended number of treatments and goal for therapy. All PA requests must include a current applicable clinical note.

Therapists may do the initial evaluation, and then submit a copy of the evaluation, PCP clinical note(s), and the treatment plan to Trillium for authorization of therapy treatment. Therapy PA requests may be submitted via the Trillium Provider Portal or by faxing the completed PA request form with supporting documentation to Trillium at the number on the PA form. Prior authorization must be obtained prior to therapy. Late PA requests may be returned and not processed due to untimely request submission.

To request an authorization for imaging services, submit a request through our vendor Evolent.

SPECIALIST REFERRALS

Trillium members may be referred by their PCP to a contracted specialist without a referral request submitted to Trillium for review, for any diagnosis. If the member does not have a PCP, or has not established care with the assigned PCP, the member may self-refer and the specialist may see the member, regardless of diagnosis.

After a visit, if the member requires additional office visits, and the diagnosis remains non-funded, the specialist must submit a prior authorization request, with documentation, for additional office visits.

If the member diagnosis is funded per the Prioritized List, no prior authorization is required.

Prior Authorization for Additional Non-Funded Specialist Care:

The Trillium Provider Portal is the most efficient way for providers to submit prior authorization requests for additional non-funded diagnosis specialist care. If a provider prefers to submit prior authorization requests by fax, a prior authorization request form must be completed and submitted along with supporting documentation to the fax number on the PA form.

The supporting documentation should include any information indicating a possible comorbid condition that may affect the decision. Note that the OHP Prioritized List criteria for coverage require condition codes for evaluation of coverage. Symptom codes are not covered for treatment by OHP and will not result in authorization approval if used as the diagnosis component on a PA request. Determination is made based on review of Oregon Health Plan coverage first in conjunction with funding per the Prioritized List, and then evaluated for medical appropriateness.

Substance Use Disorder Treatment Services

Trillium's goal is to have 100 percent of members who are in any of the following circumstances screened for substance use disorders:

- At an initial contact with a new member; at a routine physical exam; and at an initial prenatal care contact
- If the member evidences "trigger conditions" during a physical examination or emergency room contact *(special occasions and holidays, parties, sporting events, gambling, being around people you associate with substance use, being offered a drink or drug, fatigue, stress, free time or boredom, loneliness)*
- If the member exhibits serious over-utilization of medical, surgical, trauma, or emergency services
- If the member reports a recent overdose event or an event requiring an overdose correction

Substance use disorder treatment in Oregon is available in four levels. The contracting health plans for the Oregon Health Plan are responsible for Level I, Level II, Level III, MAT, and Detoxification. All treatment programs must be licensed by OHA. The Oregon Health Authority (OHA) and American Society of Addiction Medicine (ASAM) provides criteria for these levels.

Detoxification Services (for adults only)

II-D: Ambulatory Detoxification Services

III.2-D – Clinically-Managed Residential (Social) Detoxification

III.7-D – Medically-Monitored Inpatient Detoxification Services

IV-D – Medically-Managed Inpatient Detoxification Services

Medication Assisted Treatment (MAT)

Criteria for Level I Outpatient MAT, with the understanding that MAT can be a part of all levels of service, and not restricted to only being an outpatient treatment modality

Level I Outpatient Services

I – Outpatient Treatment (less than 9 hours per week for adults; less than 6 hours per week for adolescents aged 12-17)

Level II Intensive Outpatient/Day Treatment/Partial Hospitalization

II.I – Intensive Outpatient Treatment (9 or more hours per week for adults; 6 or more hours per week for adolescents aged 12-17)

II.5 – Day Treatment/Partial Hospitalization (20 hours or more hours per week for adults)

Level III Residential Treatment

III – Residential Treatment (adults and adolescents aged 12-17)

SUBSTANCE USE DISORDER SERVICES: REFERRAL PROCESS

Trillium allows members to self-refer for screening and assessment for all levels of treatment, and to self-refer for substance use disorder outpatient services at MAT, Level I, Level II, Level II.5, and Level III. A list of the participating treatment facilities is included in the Provider Directory.

While members may self-refer for screening, assessment, and outpatient treatment, the treatment provider agencies handle referrals to higher levels of care and will notify Trillium of any care management needs for members. The Trillium Pre-Authorization Check Tool is the most efficient provider resource for pre-authorization requirements. When a PA is needed, Trillium manages prior authorizations for all substance use disorder services. Trillium follows published ASAM and OHA criteria. Quality Improvement

QUALITY IMPROVEMENT

QUALITY PROGRAM

Trillium is a quality-driven organization that adopts continuous quality improvement as a core business strategy for the entire health plan. Trillium develops and implements a quality management strategy that is embedded within every staff role and department function, approaching quality assurance, quality management, and quality improvement as a culture, integral to all day-to-day operations. The Quality Program applies a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare, systems, and processes. This type of methodology supports Trillium in developing targeted, measurable interventions and to quickly evaluate the impact of an activity on improvement goals. Trillium provides for the delivery of quality care with the primary goal of improving the health status of its members. Where a member's condition is not amenable to improvement, Trillium implements measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member.

QUALITY PROGRAM STRUCTURE

The Trillium Boards of Directors (BoD) have authority and oversight of the development, implementation, and evaluation of the Quality Program and are accountable for oversight of the quality of care and services provided to members. The Trillium BoD support the Quality Program by:

- Adopting the initial and annual Quality Program which requires regular reporting (at least annually) to the Board, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting Quality Improvement Committee (QIC) recommendations for proposed quality studies and other quality initiatives and actions taken;
- Providing the resources, support, and systems necessary for optimum performance of quality functions;
- Designating a senior staff member as the senior quality executive ;

- Designating a behavioral health professional to provide oversight of the behavioral health aspects of care to ensure appropriateness of care delivery and improve quality of service; and
- Evaluating the Quality Program Description and Quality Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.
- The BoD delegates the operating authority of the Quality Program to the QIC. Trillium senior management staff, clinical staff, and network practitioners, who may include but are not limited to primary, specialty, behavioral, dental, and vision healthcare practitioners, are involved in the implementation, monitoring, and directing of the relevant aspects of the quality improvement program through the QIC.

The QIC is the senior management lead committee accountable directly to the BoD and reports Quality Program activities, findings, recommendations, actions, and results to the BoD no less than annually. Trillium ensures ongoing member, provider, and stakeholder input into the Quality Program through a strong QIC and subcommittee structure focused on member and provider experience. The Oregon Market QIC structure is designed to continually promote information, reports, and improvement activity results, driven by the Quality Work Plan, throughout the organization and to providers, members, and stakeholders. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved. The QIC directs subcommittees to implement improvement activities based on performance trends, and member, provider, and system needs. Additional committees may also be included per health plan need, including regional level committees as needed based on distribution of membership. These committees assist with monitoring and supporting the Quality Program.

PROVIDER INVOLVEMENT

Trillium recognizes the integral role that a provider's involvement plays in the success of its Quality Program. Provider involvement in various levels of the process is highly encouraged through provider representation. Trillium promotes PCP, behavioral health, oral, specialty, and OB/GYN representation on key quality committees such as the QIC and select ad-hoc committees.

Trillium requires all practitioners and providers to cooperate with all quality improvement activities, as well as to allow Trillium to use practitioner and/or provider performance data to ensure success of the Quality Program.

QUALITY PROGRAM PRIORITIES AND GOALS

Trillium's primary quality improvement goal is to improve members' health status through a variety of meaningful activities implemented across all care settings and aimed at improving quality of care and services delivered. The Quality Program focuses on the health priorities defined by a combination of the CDC 6|18 Initiative, Healthy People 2020 and 2030, the National Institutes of Health, and other evidence-based sources. Performance measures are aligned to specific priorities and goals used to drive quality improvement and operational excellence.

Trillium's Quality Program priorities and goals support the Centene Corporation purpose of Transforming the Health of the Communities We Serve, One Person at a Time and employing the three core brand pillars: a focus on the individual; an innovative, whole-health, well-coordinated system of care; and active local and community involvement. The mission, core pillars, and health priorities are outlined in the table below:

Transforming the Health of the Communities We Serve, One Person at a Time		
Focus on Individuals	**Whole Health**	**Active Local Involvement**
Priorities		
• Well-Coordinated, Timely, Accessible Care Delivery • Member Healthy Decisions • Home and Community Connection • Right Care, Right Place, Right Time • Member Engagement • Provider Engagement • High Value Care • Member Satisfaction with Provider and Health Plan	• Meaningful Use of Data • Prevent and Manage Top Chronic Illnesses • Manage Co-morbid Physical and Behavioral Health Diagnosis • Manage Episodic Illnesses • Manage Rare Chronic Conditions • Screen for Unmet Needs • Remove Barriers to Care; Make It Simple to Get Well/Stay Well/Be Well • Coordination of Care Across the Healthcare Continuum • Behavioral Health Integration • LTSS Quality of Life	• Local Partnerships • Population Health Improvement • Preventive Health and Wellness • Maternal-Child Health Care • Prevent and Manage Obesity • Tobacco Cessation • Opioid Misuse Prevention and Treatment • Address Social Determinants of Health • Health Equity/Disparity Reduction • Multi-Cultural Health

PERFORMANCE IMPROVEMENT PROCESS

Trillium's QIC reviews and adopts an annual Quality Program and QI Work Plan that aligns with Trillium's strategic priorities and goals and appropriate industry standards. The Quality Department implements and supports quality improvement activities as required by the state or federal contract, including quality improvement projects and accreditation needs. Focus studies and healthcare initiatives also include behavioral healthcare issues and/or strategies.

Trillium utilizes traditional quality/risk/utilization management approaches to identify activities relevant to Trillium's programs or a specific member population and that describe an observable, measurable, and manageable issue. Initiatives are identified through analysis of key indicators of care and service based on reliable data which indicate the need for improvement in a particular clinical or non-clinical area. Baseline data may come from various sources, including but not limited to: performance profiling of contracted providers, mid-level providers, ancillary providers, and organizational providers; utilization information (over-and under-utilization performance indicators); trends in member complaints, grievances and/or appeals; issues identified during care coordination; and/or referrals from any source indicating potential problems, including those identified by affiliated hospitals and contracted providers. Other initiatives may be selected to test an innovative strategy or as required by state or federal contracts. Projects and focus studies reflect the population served with consideration of SDOH, age groups, disease categories, and special risk status. The Quality Program supports accountability for Quality of Care and services provided to Trillium members.

The QIC or subcommittee/work group may also assist in barrier analysis and development of interventions for improvement. Data are re-measured at predefined intervals to monitor progress and make changes to interventions as indicated. Once a best practice is identified, control monitoring reports are implemented to monitor for changes in the process and need for additional intervention.

Improvement that is maintained for one (1) year is considered valid and may include, but is not limited to, the following:

- The achievement of a pre-defined benchmark level of performance;
- The achievement of a reduction of at least 10% in the number of members who do not achieve the outcome defined by the indica/tor (or, the number of instances in which the desired
- outcome is not achieved); and
- The improvement is reasonably attributable to interventions undertaken by Plan.

MEMBER SAFETY AND QUALITY OF CARE

The Quality Program is a multidisciplinary program that utilizes an integrated approach to monitor, assess, and promote patient safety and Quality of Care. Trillium has mechanisms to assess the quality and appropriateness of care furnished to all members including those with special healthcare needs, as defined by the State. These activities are both clinical and non-clinical in nature and address physical health, behavioral health, and social health services.

Member safety is a key focus of the Trillium Quality Program. Monitoring and promoting member safety is integrated throughout many activities across the health plan, including through identification of potential and/or actual Quality of Care events and critical incidents, as applicable. A potential Quality of Care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or signals a potential sentinel event, up to and including death of a member. Employees (including Population Health and Clinical Operations (PHCO) staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, state partners, Medical Directors, or the Board of Directors may inform the Quality Department of potential Quality of Care issues and/or critical incidents. Potential Quality of Care issues require investigation of the factors surrounding the event to make a determination of the severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential Quality of Care issues and critical incidents received in the Quality Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Trillium's critical incident management processes comply with all health, safety and welfare monitoring and reporting of critical incidents as required by state and federal statutes and regulations and meet all accreditation requirements. Management of critical incidents safeguards the health, safety, and welfare of members by establishing protocols, procedures, and guidelines for consistent monitoring and trend analysis for all critical incidents as defined by state and federal regulations and accreditation requirements.

MEDICAL RECORD REVIEW

Trillium promotes maintenance of medical records in a current, detailed, and organized manner which permits effective and confidential patient care and quality review. The standards for practitioner medical record keeping practices, which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of member

information, are outlined in the Provider Manual. Trillium conducts medical record reviews for purposes including, but not limited to, utilization review, quality management, medical claim review, or member complaint/appeal investigation. Providers must meet specific requirements for medical record keeping; elements scoring below a determined benchmark are considered deficient and in need of improvement.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). It is used to measure the effectiveness and Quality of Care received by members of a managed care plan. As federal and state governments move toward a healthcare industry driven by quality, HEDIS rates are becoming increasingly important, not only to the health plan, but to the individual provider.

HEDIS RATE CALCULATIONS

HEDIS rates are calculated in three ways: administrative data, hybrid data, and Electronic Clinical Data Systems (ECDS) data. Administrative data consists of claim and encounter data submitted to the health plan. Most measures are typically calculated using administrative data including Breast Cancer Screening (routine mammography), Osteoporosis Management in Women Who Had a Fracture, Access to Preventative/Ambulatory Health Services, and Mental Health Utilization.

Hybrid data calculations can consist of both administrative and ECDS data, and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims, encounter, or supplemental data. Accurate and timely claims and encounter data, and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include screenings and results for diabetic members (including HbA1c, dilated retinal eye exams, and blood pressures), and Controlling High Blood Pressure (for members with hypertension).

Electronic Clinical Data Systems (ECDS) reporting includes, but is not limited to, member eligibility files, EHRs, clinical registries, Health Information Exchanges (HIE), electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries. ECDS also includes the claim system data which is captured through administrative data. ECDS reporting expands the method for collecting and reporting clinical data and leverages the extensive information available in electronic datasets used in member care.

WHO CONDUCTS MEDICAL RECORD REVIEWS (MRR) FOR HEDIS?

HEDIS medical record review (MRR) is conducted by the Quality Department. Trillium may contract with an independent national chart retrieval vendor to collect records on its behalf. MRR for HEDIS can occur anytime throughout the year but are usually conducted January through May. Prompt cooperation with the MRR process is greatly needed and appreciated. Trillium Quality staff can support providers during this process through remote EMR access, reducing impact on your staff and resources. Trillium providers may request assistance by calling the Quality Improvement department at 877-600-5472 or emailing HEDIS_Coordinator@trilliumchp.com. As a reminder, sharing of Protected Health Information (PHI) that is used or disclosed for purposes of treatment, payment, or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. Prior to release of data, Trillium requires the chart retrieval vendor to sign a HIPAA compliant Business Associate Agreement.

HOW CAN PROVIDERS IMPROVE THEIR HEDIS SCORES?

Understand the specifications established for each HEDIS measure

Submit claims and encounter data correctly, accurately, and on time for each service rendered.

- All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Trillium. Claims and encounter data are the most efficient way to report HEDIS.
- If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation from each provided service and document conversations had with members. Include values and results of any completed testing, screening, or monitoring in the medical record.
- Submit claims and encounter data using CPT and CPT II codes related to HEDIS measures such as diabetic eye exam and blood pressure.
- Establish a recurring supplemental data file with Trillium to capture additional events, diagnoses, and values.

If you have any questions, comments, or concerns related to the annual HEDIS project or medical record reviews, please contact the Quality Department at: 877-600-5472 or HEDIS_Coordinator@trilliumchp.com

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

Trillium supports continuous ongoing measurement of member experience by monitoring member inquiries, complaints/grievances, and appeals; member satisfaction surveys; member call center performance; and direct feedback from member focus groups and other applicable committees. The Quality Department analyzes findings related to member experience and presents results to the QIC and appropriate subcommittees.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Plan Survey assesses patient experience in receiving care. CAHPS results are reviewed by the Quality team and leadership to identify specific recommendations for performance improvement interventions or actions.

The following comprises the CAHPS measures that are impacted by providers, either directly or indirectly:

- Getting Care Quickly (comprised of multiple questions related to routine and urgent appointments);
- Getting Needed Care (comprised of multiple questions related to getting care, tests, or treatment necessary and getting an appointment with a specialist);
- Coordination of Care;
- Rating of Health Plan;
- Rating of All Health Care;
- Rating of Personal Doctor;
- Rating of Specialist Seen Most Often;
- The CAHPS survey is sent out each year and measures member satisfaction.

CAHPS - Outpatient Mental Health Survey (OPMH)

Trillium also supports ongoing measurement of member experience with mental health and substance use disorder services. The Outpatient Mental Health Survey (OPMH) assesses adult and child patient experience in receiving mental health care over the prior six months. OPMH results are reviewed by the Quality team and leadership to identify specific recommendations for performance improvement interventions or actions.

This annual survey assesses the following measures of patient experience. Many of the metrics are comprised of multiple questions:

- Getting Appointments for Prescription Medicines
- Getting Mental Health Counseling
- Communication with Mental Health Counselor
- Goal Setting
- Getting Help Between Appointments
- Rating of Mental Health Counselor
- Unmet Need for Mental Health Services
- Financial Barriers for Mental Health Services

Understanding the survey questions to which members are responding may inform provider/patient conversations, areas of opportunity, and care planning, leading to better patient outcomes, effective treatment, and member experience.

Complaints, Appeals, and Grievances

Trillium provides a complaint, grievance, and appeal process for all members. Trillium maintains written procedures for accepting, processing, and responding to all member complaints, grievances and appeals. In addition to Trillium's internal procedures, members are fully informed of the contested case hearing process.

A member, or authorized representative acting on the member's behalf, has the right to file a grievance for any matter, file an appeal, and request a contested case hearing.

Grievances may be filed at any time orally or in writing by fax, mail, or email with Trillium, OHA, or a delegated subcontractor of Trillium. Trillium acknowledges grievances upon receipt. Complaints may also be termed concerns, problems, or issues by the member and may or may not be identified by the member as needing resolution. The appropriate Trillium staff member will document, investigate, and attempt to resolve the complaint or grievance.

Trillium fully complies with and implements all contested case hearing decisions. Neither implementation of a hearing decision nor a member's request for a hearing may be a basis for a request by Trillium for disenrollment of a member. Trillium recognizes that expressed concerns, complaints, grievances, and the appeal process are sensitive and confidential. All persons having access to the information are required to agree to preserve and protect the confidentiality of the information.

Trillium acknowledges formally that any finding reportable under the child or adult abuse reporting acts will be reported promptly as required by law.

MEMBER'S RIGHT TO COMPLAIN

It is in Trillium's members' and practitioners' best interests to resolve member concerns and complaints at the earliest opportunity.

Trillium provides members with reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, and contested case hearing requests. Trillium provides members with a toll-free number and free interpreter services for filing a grievance or an appeal. Members have a right to have an attorney or member representative at a contested case hearing.

Trillium members should be encouraged to contact Member Services if they have a concern or complaint. Trillium members also have the right to present their complaint to OHP using the Oregon Health Plan Complaint Form (Form 3001 (6/19)). Additionally, members who are dissatisfied with Trillium's handling of their complaint may also contact OHP for further assistance.

Providers may not discourage a member from filing a grievance or use the filing or resolution as a reason to retaliate against a member or to request member disenrollment. Providers agree to make complaint, appeal, and contested case hearing request forms available to members.

Trillium does not take punitive action against providers who request an expedited resolution or who support a member's grievance or appeal.

If a member has a concern or complaint about their experience at your practice, and expresses it to you or your office staff, attempt to resolve the issue promptly. Trillium values an educative approach in resolving complaints with members and a conversation with a member of your staff may be sufficient.

You may direct the member to contact Trillium Member Services at 877-600-5472 for assistance. Members may also file a grievance online at trilliumohp.com/grievances. Members can mail a complaint to:

Trillium Community Health Plan
ATTN: GRIEVANCES
P.O. Box 11740
Eugene, OR 97440-3940

RESOLUTION OF CONCERNS OR COMPLAINTS

Grievances are accepted both verbally and in writing. If a complaint is made verbally, the staff member receiving the complaint will assist the member with filing the complaint on the member's behalf. If a member files a written complaint with Trillium, all grievances received either verbally or in writing are forwarded to the Quality staff to investigate and review.

Trillium's Quality team may further investigate the complaint by contacting you or your office staff. Grievance decisions include the review of each individual element of the complaint, addressing each element specifically in the response.

Grievances must be resolved within five (5) working days from the date the complaint is made. If a Trillium Quality team member cannot resolve the complaint within five (5) working days, Trillium notifies the member in writing that the resolution is delayed for up to 30 total calendar days and provides the specific reason for the delay. The decision on a member's written complaint is sent to the member no later than 30 calendar days from the date the complaint is received.

QUALITY OF CARE COMPLAINTS

Trillium's Medical Director reviews all written Quality of Care complaints and may conduct a follow-up inquiry or make recommendations for other follow-up research. Quality staff logs and reviews all verbal and written Quality of Care complaints for specific trends.

MEMBER APPEALS

After Trillium denies a service or benefit, the member receives a Notice of Action letter explaining why the service or benefit was denied. The member may appeal decisions for denial, reduction, limitation, discontinuation, or termination of services or benefits made by Trillium. An appeal may also be made by the member's representative, a provider with the member's written consent, or the legal representative of a deceased member's estate.

An appeal must be filed no later than 60 calendar days after the denial is made. The appeal will be reviewed by appropriate staff and a written decision made no later than 16 calendar days from the day of receipt. Expedited appeals will be reviewed by appropriate staff and a written decision made no later than 72 hours from the time of receipt.

Members have the right to request continuation of benefits during an appeal or contested case hearing. The member's request to extend benefits must be filed within 10 calendar days of the Notice of Action or Notice of Adverse Benefit Determination. If Trillium's action is upheld in a contested case hearing, the member may be liable for the cost of the continued benefits.

Appeals can be submitted by contacting us by fax: 866-730-0958 or mail: Trillium OHP Appeals, P.O. Box 11740 Eugene, OR 97440-3940 or by phone at 541-485-2155 or toll-free at 1-877-600-5472 (TTY 711), Monday to Friday, 8 a.m.–5 p.m.

Contested Case Hearings

All denial Notices of Action sent by Trillium include information on how to request a contested case hearing. A hearing can only be requested after notification of an adverse appeal decision is received or if Trillium fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame. A hearing must be held within 120 calendar days from the date of Trillium's adverse appeal decision letter. Hearing requests can be submitted by calling OHA at 800-273-0557 (TTY 711) or by visiting https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3302.pdf

Additional information about appeals, hearings, grievances and member rights can be found on the Notice of Adverse Benefit Determination issued with every adverse benefit decision, the Member Handbook, and Provider Manual. Providers will be informed of any updates to procedures or time frames contained within this document within 5 days of approval of OHA.

QUALITY IMPROVEMENT COMMITTEE (QIC)

A report looking at member satisfaction, including appeal and grievance trends, is presented to the Trillium QIC annually. Committee members review the report and have authority to make recommendations for action based on the results. The Committee meeting's minutes document review and subsequent recommendations.

A Quarterly Complaint Report is submitted to DMAP within 45 days of the end of each calendar quarter. Trillium may encourage the member to use the Trillium complaint or appeal processes, as appropriate, but must not discourage the member from requesting a DMAP hearing for denied claims or authorizations. If the member files a request for a DMAP hearing, DMAP will immediately notify Trillium.

If the member is unable to advocate for themself, the Care Coordination Nurse or Grievance and Appeal Coordinator will communicate with the member's caseworker to identify the member's personal representative. The Care Coordination Nurse will communicate with the personal representative to allow access to Trillium's complaint and/or appeal process.

Provider Complaints

Providers have the right to make a complaint or file a grievance with Trillium. A provider complaint is not required to follow a specific format as long as it provides a clear written expression of the disagreement or concern.

Complaints against a Trillium staff member from a provider can be addressed to Appeals and Grievances, and will be forwarded to the appropriate staff member’s supervisor and to Human Resources.

Mail to:

Trillium Community Health Plan Appeals & Grievances
P.O. Box 11740
Eugene, OR 97440

Requests for Redetermination

All corrected claims, requests for redetermination, or claim disputes must be received within 180 calendar days from the date of the Explanation of Payment (EOP). Trillium Community Health Plan shall process and finalize all adjusted claims, requests for redetermination, and disputed claims to a paid or denied status 45 business days from receipt of the corrected claim, request for redetermination, or claim dispute.

See OAR 410-120-1570, or page 14 of the Trillium OHP Billing Guide for more detailed instructions.

Appeal vs. Redetermination Per OAR, an appeal addresses primarily legal or policy issues, whereas redetermination is when a provider disagrees with an initial claim determination and requests a review for re-determination of the denied claim payment.