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Introduction

WELCOME
Welcome to Trillium Community Health Plan (Trillium). We 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 on behalf of Oregon Health Plan (OHP) members in Washington, Multnomah, Clackamas, Lane and Western Douglas counties.

A CCO is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care 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 15 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 strong, community-based healthcare system that focuses on prevention and delivering high-quality service to our members through coordination, collaboration and partnerships.

MISSION STATEMENT
Our mission is to listen to, respect and empower our members, in partnership with the provider community, to achieve better health by addressing our members’ unique needs and seeking innovative solutions.
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.

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<tr>
<th>Resource</th>
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<tr>
<td>Appeals &amp; Grievances</td>
<td>(877) 600-5472</td>
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<td>Authorizations</td>
<td>(877) 600-5472</td>
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<tr>
<td>Billing &amp; Claims</td>
<td>(541) 485-2155</td>
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<tr>
<td></td>
<td>Trillium Community Health Plan, Attn: Claims</td>
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<tr>
<td></td>
<td>P.O. Box 5030</td>
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<td>Farmington, MO 63640-5030</td>
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<td>Confidential Complaint Hotline</td>
<td>(877) 367-1332</td>
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<td>Credentialing/Enrollment Services</td>
<td>(877) 600-5472</td>
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<td></td>
<td>Fax: (844) 890-4957</td>
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<td><a href="mailto:TCH_ProviderOperations@Centene.com">TCH_ProviderOperations@Centene.com</a></td>
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<tr>
<td>Medical Management</td>
<td>(877) 600-5472</td>
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<td>Member Services</td>
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<td>OHA Provider Services</td>
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<td>Pharmacy</td>
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<td>Website</td>
<td><a href="http://www.trilliumohp.com">www.trilliumohp.com</a></td>
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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:

- Advance Directive Forms
- Authorization Forms
- Billing Manual
- Formulary
- Pre-Authorization Check Tool
- Provider communications archive
- Provider training

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 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 can be found at: https://provider.trilliumhealthplan.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. Applications may be accessed at the Council for Affordable Quality Healthcare (CAQH) website by selecting the Universal Credentialing DataSource link.

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 years with a written explanation of any gaps of a prescribed time frame (initial credentialing only)
- Current, unencumbered 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
- Malpractice 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
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 the responsibility 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 oversight 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 can 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 for 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 to determine whether a practitioner should be admitted or retained as a participant in Trillium’s network.

Practitioners are notified 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**

Practitioners are notified 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 correct 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. Notification to Trillium must occur within 48 hours of Trillium’s notification to the practitioner of a discrepancy or within 24 hours of a practitioner’s review of his or her 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 after 10 working days the primary source information remains in dispute, the practitioner is subject to administrative denial or termination.
PRACTITIONER CREDENTIALING APPEALS AND RECONSIDERATIONS

Practitioners whose participation in Trillium’s network has been denied, reduced, suspended, or terminated for quality of care/medical disciplinary causes or reasons are provided notice and opportunity for an appeal. 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.

Affected practitioners whose original actions are overturned are granted admittance or continued participation in Trillium’s network. 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.

Affected practitioners whose original determinations have been upheld are given formal notice of this decision in an expeditious manner and no more than 60 calendar days of the fair hearing panel’s ruling. The actions are reported 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 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 timeframes.

TRILLIUM CREDENTIALING FOR OTHER PRACTITIONERS & SPECIALTIES

The sections below describe Trillium’s policies for Organizational Providers, Primary Source Verification and Recredentialing policies, Recredentialing of Physicians and Other Healthcare.
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 Facility
- 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:

- Copy of a current accreditation certificate appropriate for the facility. If not accredited, then a copy of the most recent DHHS/DPH site survey as described above is required. 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
- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess 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

Organizational providers are recertified at least every 36 months 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/credentialing 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. This evaluation, which includes applicable primary source verification, is conducted in accordance with health plan, state and federal regulatory requirements and accrediting entity standards. Practitioners are subject to recredentialing within 36 months. Only licensed, qualified practitioners meeting and maintaining Trillium standards for participation requirements are retained in the Trillium network.

Practitioners due for recredentialing must 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 of 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

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. A review of member complaint reports or related information is conducted at least every 60 days. An exception to the threshold is made if the nature of the concern may cause potential harm to Health Net 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
Each criterion on the site tool is weighted 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.

Participating practitioners who refuse an office site evaluation, do not meet the CAP within a specified timeframe or refuse to participate in a CAP are referred 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. Term length for locums will not exceed 90 days unless extenuating circumstances are submitted in writing and approved by the Chief Medical Officer. In no case will a locum tenens term exceed 120 days.

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

RESPONSIBILITIES OF PRIMARY CARE PHYSICIAN
Primary Care Physicians (PCPs) are responsible for coordinating and managing a member’s care. PCPs are required to screen members for health care 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, child care and safety needs. PCPs are required to use Medically Appropriate and Evidence-Based treatments in meeting members’ health care 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 health care needs and incorporate it in the member’s medical record.

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.

One of the requirements that Trillium must ensure is the 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](http://www.oregon.gov/oha/home).

**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 he or she becomes 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 he or she becomes 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 his or her 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 members are instructed to ask their PCPs to coordinate care with a specialist. Referred members may be seen, 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 Trillium coordinated care procedures and policies are followed correctly.
- Ensure that treatment and preventive services provided are documented and incorporated 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**

Providers are expected to provide preventive care promoting physical, oral, and mental 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. Providers are required to report to Trillium preventive services rendered to members, and are subject to Trillium’s Medical Case Management and Record Keeping policies.
Access to Care

Trillium is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities and their companions. 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. Provider’s must have provisions for patients with visual and/or hearing impairments, and have procedures for using translation services for members that require them – or by utilizing Trillium’s translation service.

ACCESSIBILITY OF PROVIDERS

Trillium requires providers to follow the appointment accessibility standards of the Oregon Health Plan 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 care 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 twenty-four (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 families must be provided with an immediate assessment and intake;
- Members with opioid use disorders must be provided with an assessment and intake within 72 hours;
- Members requiring medication-assisted treatment must be provided with an assessment and induction no more than 72 hours after request and provide no fewer than 2 follow-up appointments to such members within 1 week after the assessment and induction;
- Special Health Care Needs 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:

**PRIMARY CARE APPOINTMENT ACCESS STANDARDS**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/regular care appointment</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>SHCN Routine/regular care appointment</td>
<td>21 calendar days</td>
</tr>
<tr>
<td>Adult Urgent/Sick Visit</td>
<td>72 hours</td>
</tr>
<tr>
<td>Pediatric Urgent/Sick Visit</td>
<td>72 hours</td>
</tr>
<tr>
<td>After-Hours</td>
<td>• By medical staff directly</td>
</tr>
<tr>
<td></td>
<td>• By an answering service that could reach an on-call provider within 30 minutes</td>
</tr>
<tr>
<td></td>
<td>By a recorded or automated message, or that has both emergency instructions and a way to reach medical staff</td>
</tr>
</tbody>
</table>

**BEHAVIORAL HEALTH APPOINTMENT ACCESS STANDARDS**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-life-threatening emergency care</td>
<td>Directed to a crisis center or ER Within 6 hours if care with a behavioral health practitioner is not available</td>
</tr>
<tr>
<td>Urgent care</td>
<td>24 hours</td>
</tr>
<tr>
<td>Initial visit for routine care</td>
<td>10 business days</td>
</tr>
<tr>
<td>Follow-up Routine Care</td>
<td>Non-prescribers: within 14 calendar days</td>
</tr>
<tr>
<td></td>
<td>Prescribers: within 90 calendar days</td>
</tr>
</tbody>
</table>

**SPECIALTY CARE APPOINTMENT STANDARDS**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/regular care appointment</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>SHCN Routine/regular care appointment</td>
<td>45 calendar days</td>
</tr>
</tbody>
</table>

**DENTAL CARE APPOINTMENT STANDARDS**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/regular care appointment</td>
<td>Eight weeks</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>24 hours or referred to ER</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>One week</td>
</tr>
</tbody>
</table>

*These access standards were updated June 2020.

Wait times for scheduled appointments shall not exceed 60 minutes. After 30 minutes, members must be given an update on waiting time with an option of waiting or rescheduling the appointment. 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.
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. After-hours coverage must be accessible using the medical office’s daytime telephone number.

MEMBERS WITH VISUAL AND/OR HEARING IMPAIRMENT
Providers should be prepared to meet the needs of the visually and/or hearing impaired. To arrange for a sign language interpreter to be present at an appointment, contact Trillium Member Services at (877) 600-5472 at least one working day before the appointment.

For urgently needed sign language interpreter services, call Linguava at (503) 265-8515.

If you do not have the ability to meet the needs of a patient/member or a particular disabled population, please contact Member Services at (800) 600-5472 and we will ensure that arrangements are made for care that will meet the member’s needs.

NON-ENGLISH SPEAKING MEMBERS
Trillium has provisions for translation services. Trillium can arrange for a Spanish interpreter to be present for most appointments. Contact Member Services at (800) 600-5472 at least one business day in advance.

For urgently needed or emergent non-English language interpreter services, a telephone interpreter can be arranged through Linguava at (503) 265-8515. Use this number when it is not possible to arrange ahead of time for an interpreter to be physically present. To ensure that non-English speaking members receive accurate information, we encourage you to contact us or use a staff person trained in translation of medical terminology and information. Asking family members or friends to act as interpreter for the patient is not the appropriate action, since these persons are not usually familiar with medical terms, and translation errors may be made or information be incorrectly communicated, overlooked, or withheld.

There is no charge to the member for translation services.

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

Other types of interpretation services, such as on-site interpretation, video interpreting, and document translating, may be required under certain circumstances. These services are the financial responsibility of the medical group as defined in the Americans with Disabilities Act (ADA). According to the ADA, interpretation services must be available to all medical group patients to communicate complicated medical information. PCP offices are to have signs in the primary language of each substantial population of non-English speaking members in their practices.
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 he/she has 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 are instructed in the Member Handbook to go to the nearest emergency room or call 911. Emergency services can only be authorized in cases of true emergencies, and only as long as the emergency exists. Members are also advised to contact their PCP for follow-up and/or transfer of care.

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 can be safely transferred to a participating hospital in coordination with Trillium’s Care Coordination team.

URGENT CARE SERVICES
Members are instructed to contact their PCP for all medical care, including urgent care. Calls from members, which are urgent in nature, must be responded to within 30 minutes. If the member’s need is urgent, the PCP shall provide or arrange for appropriate care.

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 will work with PCPs to provide counseling to members who inappropriately use emergency room services. 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
Providers are required to maintain medical and financial records. Medical records of members shall be preserved by a provider for a time period of no less than ten (10) years. Finance records should be in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. Provider agrees that Trillium, OHA, CMS, the Secretary of State’s Office, DHHS, the Office of the Inspector General, the Comptroller General of the United States, the Oregon Department of Justice Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all records and any subcontractors to perform examinations and audits and make excerpts and transcripts to evaluate the quality, appropriateness and timeliness of services. Providers also must agree that the foregoing entities may, at any time, inspect the premises, physical facilities, and equipment where Trillium OHP activities or work is conducted.
Trillium Members

MEMBER IDENTIFICATION
Members are instructed to bring their Member Identification 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.

Lane County member cards:

Portland Metro Area member cards:

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 can also be verified by calling Member Services at (877) 600-5472, or accessing the State of Oregon’s Provider Web Portal.

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

Information regarding the State of Oregon’s provider services can 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 Member 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

Each individual family member may choose the same family PCP or a different PCP. Each member will have his/her 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.

PCP Selection Limit
Trillium allows up to three member-initiated PCP changes in a 12-month period.

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 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](http://oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List)

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, and administered by Trillium includes:

- Behavioral health treatment services
- Diagnosis and screening for all conditions on the prioritized list, even those for which treatment may not be covered
- Family planning services
- 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
• 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.

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.

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
- Rides to and from select Health-Related Services, approved by 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 on a percent 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 and 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 members up 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 necessary forms or passes. Reimbursement requires the member to log their trip information and obtain signature from their provider office, and submit the completed form within 45 days of the appointment to the brokerage.
DENIAL OF RIDES
If the ride is denied, based on the program rules and according to OHP rules, the member will receive a verbal denial. The member will also receive 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 your 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.

<table>
<thead>
<tr>
<th>Eugene Region</th>
<th>Portland Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane, Western Douglas, Western Linn Counties</td>
<td>Clackamas, Multnomah, Washington Counties</td>
</tr>
<tr>
<td>[Image: Lane Transit District]</td>
<td>[Image: MTM]</td>
</tr>
<tr>
<td><a href="mailto:Ridesource@ltd.org">Ridesource@ltd.org</a></td>
<td><a href="http://www.mtm-inc.net">www.mtm-inc.net</a></td>
</tr>
<tr>
<td>(541) 682-5566</td>
<td>(877) 583-1552 (TTY: 711)</td>
</tr>
<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>(877) 800-9899 (TTY: 711)</td>
<td></td>
</tr>
</tbody>
</table>

**HOURS OF OPERATION**

<table>
<thead>
<tr>
<th>Eugene Region</th>
<th>Portland Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday through Friday 8:00 am – 5:00 pm</td>
<td>Sunday through Saturday 8:00 am – 5:00 pm 24/7 for urgent rides or after leaving the hospital</td>
</tr>
</tbody>
</table>
Pharmacy 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.

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 are 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. Provider’s 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 the right to refer themselves to a Traditional Health Worker for covered services.

Providers are required to guarantee that Trillium member’s access to covered services is at least equal to the access available to other persons served by the provider and treated with respect.

For children and others unable to make their own medical care choices, a legal guardian or agent has responsibility for ensuring member rights on his or her 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 health care and lifestyle choices. Providers may charge members for reasonable duplication costs when they request copies of their records.

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 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 will remain responsible to provide acute, urgent or emergent care to the member.

The provider will make medical records available to another provider upon receiving a signed release from 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. All efforts to resolve the situation, including the options presented to the member and evidence that the member’s response was considered must be documented. 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 Oregon Administrative Rule 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 will direct you 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.

The practitioner performing the procedure must attach a copy of the correctly completed consent form to the claim. If a correctly completed consent form is not attached, the claim, and all associated claims (hospital, anesthesiology, etc.), will be denied.
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, Claims Payment & Authorizations

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 the Member services department by phone at (877) 600-5472. Mail OHP Claims to:

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

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 approvals, it is the responsibility of the requesting practitioner to notify the patient of an approved authorization.

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. If there is a coverage problem with the requested procedure or diagnosis that may delay determination, we will notify the practitioner as soon as possible.
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. 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.

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 Prior Authorization request supporting documentation should include both a description of the initial evaluation and a description of treatment provided to date.

Chemical Dependency Services
Trillium’s goal is to have 100 percent of members who are in any of the following circumstances screened for chemical dependency:

- At an initial contact with a new member or at a routine physical exam thereafter;
- At an initial prenatal care contact;
- If the member evidences “trigger conditions” during a physical examination or emergency room contact;
- If the member exhibits serious over-utilization of medical, surgical, trauma, or emergency services.

Alcohol and chemical dependency treatment in Oregon is available in four levels. The contracting plans for the Oregon Health Plan are responsible for Level I, Level II, Level III, Opioid Maintenance Therapy, and Detoxification. The DHS Addictions and Mental Health Division (AMH) has determined these levels. All treatment programs must be licensed by AMH. AMH and ASAM PPC-2R have determined the criteria for these levels.
Detoxification Services (for adults only)

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

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

IV-D – Medically-Managed Inpatient Detoxification Services

Opioid Maintenance Therapy (OMT)

Criteria for Level I Outpatient OMT, with discussion that OMT can be in 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

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 (20 hours or more hours per week for adults).

Level III Residential Treatment

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

CHEMICAL DEPENDENCY SERVICES REFERRAL PROCESS

Trillium allows self-referral for members to access screening and assessment for all levels of treatment, and self-referrals for alcohol and chemical dependency outpatient services at OMT, 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 alcohol and chemical dependency services. Trillium follows published ASAM and AMH criteria.

Smoking Cessation Services

Trillium members are eligible for the Quit For Life™ 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.

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

MEDICAL MANAGEMENT

The mission of Medical Management 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, and skilled nursing facilities (SNF), home care services, DMEPOS, outpatient care, intensive outpatient programs, partial hospital facilities, and office visits.

MEDICAL MANAGEMENT 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 Medical Management 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 can call the Provider Services at (877) 600-5472 and select the appropriate transfer option. Providers can 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 Assessments (HRS) are available for members to complete online, 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.

An interdisciplinary care team approach is taken 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 an effective 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.

Intensive care coordination services are also provided by the care coordination team for members on the Oregon Health Plan. This program provides assistance to members who have complex, exceptional or special needs, such as members age 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 can 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.

Success comes from coordinated actions among care providers focusing on those members at high risk for repeated acute care episodes, and linking them quickly to the services that are most necessary to support the discharge plan and prevent fractured care.

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 will review current residential facility, hospital inpatient, and hospital outpatient census reports on a daily basis. This team of nurses will communicate 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 processes authorization for SNF stays for members. 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. Transition services through the Trillium Care Coordination program will be provided and carried over from the Concurrent Review.

CARE PLANS
Care plans are developed within Trillium’s 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 exist via provider portal, as well as fax or mail. Care plans are shared with providers based on needs and changes in the member’s needs, as care plans are updated with each member interaction and are focused 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 can result from high-risk pregnancies. The program offers support for pregnant women 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)

Member Connections Representatives (MCRs), (also called Community Health Workers), serve as liaisons between communities, individuals and Coordinated Care Organizations. They are non-traditional healthcare professionals and provide non-clinical health and/or nutritional guidance, and social assistance to community residents.

As community health liaisons, MCRs can provide direct services to members in a culturally and linguistically appropriate manner, handling health promotion, as well as assist 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 including navigation of benefits, home and community visits, support readmission reduction and patient referrals to community agencies.

Member Connections Representatives’ responsibilities include connecting members to appropriate community resources and social services, and identifying barriers to care when appropriate. The scope of MCR engagement can either be structured broadly, encompassing multiple patient conditions and communities, or narrowly, where MCR services are targeted to a more focused patient population.

Members can be referred to work with MCRs and the Care Coordination team. Members referred will be reviewed and determined the most appropriate level of intervention and engagement.

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 web site under Provider Resources.

Trillium can also supply 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 & 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 include 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 can refer members to Trillium as necessary if the provider believes that complex care management is needed.

Quality Management
QUALITY MANAGEMENT & IMPROVEMENT PROGRAM
Trillium’s culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management and Improvement (QMI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, population health management, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

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. The QMI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, Trillium’s QMI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.
QMI PROGRAM STRUCTURE

The Trillium Board of Directors (BoD) oversees development, implementation, and evaluation of the QMI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to members. The Trillium BoD supports the QMI Program by:

- Adopting the initial and annual QMI Program which requires regular reporting (at least annually) to the Board, and establishes mechanisms for monitoring and evaluating quality, utilization, and risk;
- Supporting QIC recommendations for proposed quality studies and other QMI initiatives;
- Providing the resources, support and systems necessary for optimum performance of QMI functions;
- Designating a senior practitioner as the Senior Executive for Quality Improvement (SEQI); and
- Evaluating the QMI Program and QI Work Plan annually to assess whether program objectives were met and recommending adjustments when necessary.

The BoD delegates the operating authority of the QMI Program to the Quality Improvement Committee (QIC). Trillium senior management staff, clinical staff, and network providers, who may include but are not limited to, primary, specialty, behavioral, dental, and vision health care providers, are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the QIC or other internal sub committees, which are directly accountable to the BoD, and also participate in a number of Joint Operational Committees focused on QMI activities.

The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, Plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the QMI, Utilization Management, and Credentialing programs.

The scope of the QIC includes:

- Oversight of the QMI activities to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as NCQA;
- Annual development of the Trillium QMI Program Description and Work Plan incorporating applicable supporting department goals as indicated;
- Development of quality improvement studies and activities, and reporting of findings to the BoDs;
- Annual review and approval or acceptance of the applicable Credentialing, Pharmacy, Utilization Management, and Case Management program descriptions and work plans as developed by the appointed subcommittees to facilitate alliance with strategic vision and goals;
- Evaluation of the effectiveness of QMI activities to include analysis and recommendations regarding identified trends, follow-up, barrier analysis, and interventions required in order to improve the quality of care and/or service to members and implement corrective actions as appropriate;
- Prioritization of quality improvement efforts, facilitation of functional area collaboration, and assurance of appropriate resources to carry out QMI activities;
- Review and establishment of benchmarks or performance goals for each quality improvement initiative and service indicator;
- Review and approval of due diligence information for any potential delegated entity and the annual oversight of audit outcomes for those entities already delegated;
- Adoption of preventive health and clinical practice guidelines to promote appropriate and standardized quality of care and monitoring of clinical quality indicators (such as HEDIS, adverse events, sentinel events, peer review outcomes, quality of care tracking, etc.) to identify deviation from standards of medical management; and supporting the formulation of corrective actions, as appropriate.

**PROVIDER INVOLVEMENT**

Trillium recognizes the integral role that a provider’s involvement plays in the success of its QMI Program. Provider’s 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 QMI Program.

**QUALITY MANAGEMENT PROGRAM GOALS AND OBJECTIVES**

Trillium’s primary quality improvement goal is to improve members’ health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered. Specific measures, performance targets and benchmarks are listed in the QI Work Plan where applicable.

Goals

Quality Improvement goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Trillium members;
- Trillium network quality of care and service will meet industry-accepted standards of performance;
- Services will meet industry-accepted standards of performance;
- Fragmentation and/or duplication of services will be minimized through integration of quality improvement activities across Trillium functional areas;
- Member satisfaction will meet established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets.
- Compliance with all applicable regulatory requirements and accreditation standards is maintained.
- Coordination of medical and behavioral health services will meet established performance targets.
- Increase member engagement in performance improvement program initiatives.

Trillium’s QMI Program objectives include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
• To select areas of study based on demonstration of need and relevance to the population served;
• To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
• To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes;
• To allocate personnel and resources necessary to:
  • support the QMI Program, including data analysis and reporting;
  • meet the educational needs of members, providers and staff relevant to quality improvement efforts;
• To seek input and work with members, providers, and community resources to improve quality of care;
• To oversee peer review procedures that address deviations in medical management and health care practices and devise action plans to improve services;
• To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
• To recommend and institute focused quality studies in clinical and non-clinical areas, where appropriate;
• To serve members with complex health needs;
• Conduct and report annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) certified Healthcare Effectiveness Data and Information Set (HEDIS®) results for Trillium members, as applicable;
• Conduct and report annual Health Outcomes Survey (HOS) results for Trillium members, as applicable;
• Achieve and maintain NCQA accreditations for appropriate products;
• Monitor for compliance with regulatory and accreditation requirements.

PERFORMANCE IMPROVEMENT PROCESS
Trillium’s QIC reviews and adopts an annual QMI Program and QI Work Plan that aligns with Trillium’s strategic vision and goals and appropriate industry standards. The QMI Department implements and supports performance/quality improvement activities as required by the state or federal contract, including quality improvement projects and/or chronic care improvement projects as required by the state or federal regulators, and accreditation needs. Focus studies and health care initiatives also include behavioral health care 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: performance profiling of contracted providers, mid-level providers, ancillary providers and organizational providers; provider office site evaluations; focus studies; utilization information (over-and under-utilization performance indicators); sentinel event monitoring; 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 in terms of age groups, disease categories, and special risk status.

The QIC assists in prioritizing initiatives focusing on those with the greatest need or expected impact on health outcomes and member experience. Performance improvement projects, focused studies, and other QMI initiatives are designed to achieve and sustain, through ongoing measurements and interventions, significant improvement over time in clinical and non-clinical care areas in accordance with principles of sound research design and appropriate statistical analysis. The QIC helps to define the study question and the quantifiable indicators, criteria, and goals to ensure the project is measureable and able to show sustained improvement. Evidence-based guidelines, industry standards, and contractual requirements are used as the foundation for developing performance indicators, setting benchmarks and/or performance targets, and designing projects and programs that assist providers and members in managing their health. If data collection is conducted for a random sample of the population, baseline and follow-up sampling is conducted using the same methodology and statistical significance and a 90% or more confidence level is determined. The QMI program provides structure and key processes to objectively and systematically monitor and evaluate quality, safety, access, efficiency and effectiveness of medical and behavioral healthcare services.

The QIC or other subcommittees 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 re-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 indicator (or, the number of instances in which the desired outcome is not achieved); and
- The improvement is reasonably attributable to interventions undertaken by Plan.

PATIENT SAFETY

Patient safety is a key focus of the Trillium QMI Program. Monitoring and promoting patient safety is integrated throughout many activities across Trillium, including through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient 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. Trillium employees (including medical management staff, member services staff, provider services staff, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the BoD may inform the QMI Department of potential quality of care issues. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QMI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.
Trillium monitors for quality of care and/or adverse events through claims-based reporting mechanisms. An adverse event is an event over which health care personnel could have exercised control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Although occurrence of an adverse event in and of itself is not necessarily a significant quality of care issue, Trillium monitors and tracks these occurrences for trends in type, location, etc., to monitor patient safety and investigates further and/or requests a corrective action plan any time a quality of care issue is definitively identified.

The QMI Program also supports patient safety initiatives in the education of practitioners, providers, and members about safe practice protocols and procedures. These initiatives include utilizing provider and member newsletter articles and mailings to communicate information regarding patient safety. Trillium may incorporate the review of practitioner and provider initiatives to improve member safety.

OFFICE SITE SURVEYS
Trillium may conduct site visits to the provider’s office to investigate member complaints related to physical accessibility, physical appearance, and adequacy of exam room and waiting room space. Site visits may also be conducted as part of the credentialing process, or as part of standard audits to ensure facility standards are being met. Standards are based on NCQA or other accreditation guidelines, state and federal regulations.

Site visits conducted by Trillium Representatives may include:

- Access for the disabled
- Adequacy of medical records keeping practices
- Adequacy of waiting and examining room space
- Availability of emergency equipment
- Clinical lab (CLIA) standards
- Cultural competence
- Licensure
- Medication administration/dispensing/storage of vaccines/drug samples
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained
- Physical accessibility
- Physical appearance
- Scheduling/appointment availability, including office protocols/policies (Access, Office Hours, Wait Time, Preventive Health Appointment)
- Staff information

At the conclusion of an office site survey, the results will be reviewed with you or a designated member of your staff. You may make a copy of your survey for your records. If there are deficiencies, you will be asked to submit a corrective action plan.

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 evaluate the effectiveness of a managed care Plan’s ability to demonstrate an improvement in preventive health outreach to its members. 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 two ways: administrative data and hybrid data. Administrative data consists of claim and encounter data submitted to the health Plan. Most measures are typically calculated using administrative data include Breast Cancer Screening (routine mammography), Use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, Access to PCP Services, and Mental Health Utilization.

Hybrid data consists of both administrative 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 or encounter 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: Adult BMI Assessment, Comprehensive Diabetes Care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures), Medication Reconciliation Post-Discharge, and Controlling High Blood Pressure (blood pressure results <140/90 for members with hypertension).

Who Conducts Medical Record Reviews (MRR) for HEDIS?
Trillium contracts with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS can occur anytime throughout the year, but are usually conducted February 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 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. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Trillium that allows them to collect PHI on our behalf.

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 and every 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 of each member service and document conversations/services
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure
If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QMI Department at: (877) 600-5472 or HEDIS_Coordinator@trilliumchp.com

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDER SYSTEMS (CAHPS) SURVEY
The CAHPS survey is a member satisfaction survey that provides information about the experiences of members with health Plan and practitioner services and gives a general indication of how well practitioners and the Plan are meeting members’ expectations. Member responses to the CAHPS survey are used in various aspects of the Quality program including monitoring of practitioner access and availability.

CAHPS survey material that may reflect on the service of providers includes:

- Appointment availability and wait times
- How well doctors communicate
- Whether members perceive they are getting needed care, tests, or treatment needed including prescriptions and access to specialists
- Whether members perceive they are getting needed care, tests, or treatment needed including specialists and prescriptions
- Whether the member received an annual flu vaccine
- Whether the personal doctor’s office followed up to give the member test results

Complaints, Appeals, and Grievances
Trillium provides a complaint, grievance and appeal process for all members. The Plan maintains written procedures for accepting, processing, and responding to all member complaints, grievances and appeals. In addition to the Plan’s internal procedures, members are fully informed of the DMAP 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 verbal 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 DMAP Appeal Hearing Decisions. Neither implementation of a DMAP hearing decision nor a member’s request for a hearing may be a basis for a request by the Plan 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 will provide members with reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or external review 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 an external review and the availability of free legal help.

Trillium members should be encouraged to contact the Member Services Department if they have a concern or complaint. However, all Trillium members have the right to present their complaint to DMAP using the DMAP Health Plan Complaint Form (Form 3001 (6/19). Additionally, members who are dissatisfied with Trillium’s handling of their complaint may also contact DMAP 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 of a grievance 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 dealing with members and a conversation with a member of your staff may be sufficient.

You may direct the member to contact Trillium’s Member Services department at (877) 600-5472 for assistance. Or they can mail a complaint to:

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

VERBAL CONCERNS OR COMPLAINTS

If the member contacts Trillium, the staff member receiving the complaint will attempt to assist the member. There must be a resolution within five working days from the date the verbal complaint is made. Trillium’s QMI team may further investigate the complaint by contacting you or your office staff.

If a Trillium QMI team member cannot resolve the complaint within five working days, the member will be notified in writing that the resolution is delayed for up to 30 total calendar days, and the specific reason for the delay will be provided.

WRITTEN COMPLAINTS

If a member files a written complaint with Trillium, those complaints will be investigated and reviewed by QMI staff. 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.

Members who fail to provide requested information within 30 days of the request by the PCP or Trillium, unless otherwise agreed upon, may have the complaint resolved against them.
Grievance decisions include the review of each individual element of the complaint, addressing each element specifically in the response.

**QUALITY OF CARE COMPLAINTS**
All written Quality of Care complaints are reviewed by Trillium’s Medical Director, who may conduct a follow-up inquiry or make recommendations for other follow-up research. Additionally, all verbal and written Quality of Care complaints are logged and reviewed for specific trends by a Grievances and Appeals Coordinator (GAC).

**MEMBER APPEALS**
Whenever 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.

All denial Notices of Action sent by Trillium include information on how to request an appeal or a DMAP Administrative 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 timeframe. A hearing must be filed within 120 calendar days from the date of Trillium’s adverse appeal decision letter.

All information concerning a member’s appeal is kept confidential, consistent with appropriate use or disclosure for treatment, payment or healthcare operations of Trillium.

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.

Members have the right to request continuation of benefits during an appeal or external review. 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 the contractor’s action is upheld in an external review, the member may be liable for the cost of the continued benefits.

For more information on the member appeals process and timeframes please refer to the Member Appeal and Administrative Hearing Policy.
The “Denial of Medical Services Appeal & Hearing Request” form is located on the Trillium website, or contact Trillium’s Member Services department at (877) 600-5472 for assistance.

**QUALITY MANAGEMENT IMPROVEMENT**
An aggregated report containing complaint and appeal data is presented to the Trillium QIC quarterly. The report is reviewed by committee members who have the authority to make recommendations for action based on the results. Documentation of the review and any subsequent recommendations are included in the minutes of each committee meeting.

The Quarterly Complaint Report is sent to DMAP within 45 days of the end of each calendar quarter. Trillium’s QMI Department will ensure compliance.

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 him/herself, the Care Coordination nurses will communicate with the member’s caseworker to determine who the member’s personal representative is. The Care Coordination nurses will communicate with the personal representative to allow access to Trillium’s complaint and or appeal processes.

**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. Box11740
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 Oregon Administrative Rules, 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.