

# 2019 Oregon Health Plan Provider Manual



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# 1. Introduction

## 1.1 About Trillium Community Health Plan

Trillium Community Health Plan (TCHP) 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 Lane and Western Douglas counties.

As a leader for innovative approaches and outstanding coordination of community-based healthcare, Trillium remains accountable and 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.

## 1.2 About This Provider 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 our members, your patients. 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 TCHP providers, it is not all-inclusive and should be used in conjunction with your contract.

In addition to the detailed operational and policy information in this manual, we encourage you to visit our public website at [www.trilliumchp.com](http://www.trilliumchp.com) and [Provider Resources Page](#) where you'll find additional important provider information, frequently-used online tools, and other useful documents for serving Trillium members.

### 30-Day Notice for Contractual Changes

For any changes in policies or processes that impact provider contracts, Trillium's policy is to give a 30 day written notice to the provider through personal delivery, fax, email, or by first class, registered or certified mail of such proposed amendment. The continued participation by provider without written objection to the proposed change within 30 days following receipt of notice of changes in policies or processes shall constitute provider's approval of such changes. (Note: Trillium dental providers should refer to the Dental Care Organizations' (DCO) partnership agreement for all administrative and operational guidance).

## 2. Contact Us

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

### Appeals & Grievances

Phone: (877) 600-5472

### Customer Service

#### Member Services

Phone: (877) 600-5472, Option 2  
Fax: (866) 703-0958  
Email: [msservices@trilliumchp.com](mailto:msservices@trilliumchp.com)

### Trillium Confidential Complaint Hotline

Phone: (877) 367-1332

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

#### Provider Services:

Phone: (877) 600-5472, Option 3

#### Provider Relations:

Phone: (877) 600-5472  
(541) 485-2155  
Email: [providerrelations@trilliumchp.com](mailto:providerrelations@trilliumchp.com)

### Billing & Claims

Phone: (541) 485-2155

#### Mail OHP Claims to:

Trillium Community Health Plan, Attn: Claims  
P.O. Box 5030  
Farmington, MO 63640-5030

### Compliance Hotline

Phone: (800) 345-1642

### Credentialing Services

Phone: (503) 213-5054  
Fax: (503) 213-2750  
Email: [credentialing@ipsoregon.com](mailto:credentialing@ipsoregon.com)

### Medical Management

Phone: (541) 762-9090  
Email: [mmcs@trilliumchp.com](mailto:mmcs@trilliumchp.com)

### Pharmacy Services

Phone: (877) 600-5472  
TTY: 711

#### Contact for:

- Exceptions to standard formulary rules
- Medication authorization
- Clinical consultation

### Trillium Leadership, Committees & Meetings

- [Board of Directors](#)
- [Leadership Team](#)
- [Clinical Advisory Panel](#)
- [Community Advisory Council \(CAC\)](#)
- [Rural CAC](#)

## 3. Trillium Provider Resources

### **Provider Portal**

The [Trillium Provider Portal](#) serves as a fast and easy way to check eligibility, prior authorizations (PAs), and claims for dates of service after 2016. 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.

#### Portal functions include:

- View member eligibility
- Submit prior authorizations and referrals for physical health, pharmacy and behavioral health
- View history and status for claims, referrals, and prior authorizations for physical health, DME, behavioral health and



The Trillium Provider Portal is available to all providers and practitioners in the Trillium network. Registration is required for full [access](#).

Please contact your Trillium Provider Relations Representative at (877) 600-5472 with questions about how to register.

## Trillium Website

The [Trillium website](#) provides general health Plan information to our providers, practitioners and members. Additionally, the [Provider Resources](#) page includes policy and procedure updates, the provider directory, formulary, the Pre-Auth Check Tool, and many other helpful resources.

## Useful Trillium Provider Links

[Advance Directives Forms](#)

[Formulary](#)

[OHP Billing Manual](#)

[Pre-Auth Check Tool](#)

[Provider Update Archive](#)

[Secure Provider Portal](#)

## Oregon Health Plan Provider Links

[DMAP Policies, Rules and Guidelines](#)

[OHP Fee Schedules](#)

## 4. Working with Trillium Community Health Plan

### 4.1 Provider Participation Requirements

#### Basic Provider 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

### 4.1 Provider Participation Requirements

#### Contracting Policy

An applicant's participation in Trillium contracts is contingent on meeting all credentialing requirements. Once an application is approved by the Credentialing and Peer Review Committee, Trillium's Contracts Department will set the effective date for the provider's contract participation. The effective date will typically be the first of the month following approval of the provider's credentials by the Credentialing and Peer Review Committee.

### 4.2 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:

- Current, unencumbered state medical license
- 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
- Continuous work history for the previous five years with a written explanation of any gaps of a prescribed time frame (initial credentialing only)
- Evidence of adequate education and training for the services the practitioner is contracting to provide
- 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
- Malpractice insurance coverage that meets Trillium standards
- Answers to all confidential questions and explanations provided in writing for any questions answered adversely

Only licensed, qualified applicants meeting these standards and participation requirements are accepted or retained in the Trillium Network.

## **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.
- Indicates a willingness to provide additional information required for the credentialing process
- Authorizes Trillium to obtain information regarding the applicant's qualifications, competence or other information relevant to the credentialing review.
- 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 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.

## 4.3 Practitioner Rights

### **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:

- 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
- Detailed instructions on how to request an appeal (informal reconsideration or formal hearing)

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:

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

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:

- 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.
- Fulfill, according to applicable current credentialing policies and procedures, all administrative credentialing requirements of Trillium's credentialing program.

## Practitioner Credentialing Investigations

Trillium investigates adverse activities identified in a practitioner's or provider's initial credentialing or recredentialing application 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:

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

## 4.4 Trillium Credentialing for Other Practitioners and Specialties

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

### 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:

- Hospitals
- Home health, hospice and home infusion providers
- SNFs
- Freestanding and ambulatory surgery centers, including abortion clinics
- Dialysis/end-stage renal disease (ESRD) care providers
- Hospices
- Clinical laboratories
- Office-based surgery suites
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy and speech pathology providers
- Portable X-ray suppliers
- Radiology/imaging centers
- Behavioral health facilities (inpatient, residential and ambulatory)
- Sleep study centers

- Urgent care centers
- Federally qualified health centers and rural health clinics
- Providers of outpatient diabetes self-management training
- Other providers as deemed necessary

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

The documentation, at a minimum, includes:

- Evidence of a 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)
- Evidence of a current, unencumbered state facility license. If not licensed by the state, the facility must possess a current city license, fictitious name permit, certificate of need, or business registration
- 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
- Professional and general liability insurance coverage that meets Trillium requirements
- Overview of the facility's quality assurance/quality improvement program upon request.

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

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

## **Organizational Providers**

- Behavioral health facilities (inpatient, residential and ambulatory)
- 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
- Clinical laboratories
- Physical therapy/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:

- Current state medical license
- Attestation to the ability to provide care to Trillium members without restriction
- 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
- 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

## **Trillium Behavioral Health Credentialing**

Trillium Behavioral Health, a department of Lane County Health and Human Services, processes paneling requests for non-licensed behavioral health outpatient practitioners employed by Trillium Community Health Plan contracted provider agencies. Qualified Mental Health Professional (QMHP), Qualified Mental Health Associate (QMHA), Mental Health Intern, Peer Support Specialist and Substance Use Disorder practitioners exempt from board licensure shall be employed by or contracted with a provider organization certified by the Oregon Health Authority and meet qualifications for their designation type as determined by the employer agency. Board Registered Intern practitioners shall be employed by a Trillium contracted provider agency.

## 4.5 Site Visits, Member Assignment, Leaves of Absence, Reinstatement, 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:

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

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:

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

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 time frame 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.

### Leaves of Absence

A Leave of Absence may be requested when a Trillium provider temporarily ceases to practice medicine in Lane County for a period of 3 to 24 months. Absences of less than 90 days are not considered leaves of absence and the procedures described below are not necessary.

A Voluntary Leave of Absence may be obtained by submitting a written notice to the Trillium office. The notice must state the approximate period of the leave (not to exceed 24 months) and the reason for the leave. Leaves of absence for military duty may be extended beyond two years on a case-by-case basis. Absences of more than 24 months, which are not for military duty, will require termination of provider status.

Participating insurance carriers will be notified of the provider's leave. During the leave period, the provider is moved to inactive status in Trillium's database system. The provider's responsibilities are suspended, including re-credentialing and committee membership. Once the leave has commenced, providers may continue to receive payments for medical care rendered prior to the leave date, however, providers are not eligible to provide or be compensated for medical services rendered under Trillium contracts during the leave period.



## Reinstatements

Prior to delivering service to patients covered by Trillium contracts, the provider must request reinstatement and receive notification of approval by Trillium's Executive Committee.

Up to 45 days prior to the end of a leave, or at any earlier time, the provider must request reinstatement by sending written notice including a summary of relevant activities during the leave, and completing a reappointment form. The provider must also assist in resolving any issues regarding potentially adverse information, which may have been identified and been pended during leave. The provider's file will be processed in a manner consistent with the re-credentialing process and submitted for evaluation and action.

The provider will receive written notification of the Executive Committee's decision and the checklist will be faxed to all participating carriers.

## 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.

Locum tenens applicants must complete and submit a locum tenens application along with copies of an Oregon medical license, current malpractice face sheet, DEA certificate, CV, and written narrative of any "yes" answers to attestation questions. In accordance with verification policies as stated above, The Trillium workforce will verify date and current standing of licensure, hospital privileges, if applicable; Board Certification, if applicable, query the NPDB and review applicable reports for federal sanction activity and state disciplinary actions. Subsequent to the verifications as listed above, the locum's file will be processed consistent with the credentialing process and submitted to the Chief Medical Officer for evaluation and action. If necessary, an expedited Executive Committee decision may be requested via teleconference or written vote via fax. If the locum tenens application is approved, an effective date, which may be retroactive, and termination date will be assigned.

## American Specialty Health Group, Inc.

Trillium contracts with American Specialty Health Group, Inc. (ASH Group) to administer and arrange Well Net alternative healthcare services, including chiropractic, acupuncture, massage therapy, or naturopathic medicine services for Trillium members in accordance with the member's applicable benefit Plan.

Phone: (800) 972-4226

Naturopathic doctors (NDs) who elect to be PCPs must contact ASH Group for members who come to their office seeking services to verify eligibility and determine whether the member is covered under the PCP program or existing naturopathy specialty services at the number above or via [ASHLink \(www.ashlink.com\)](http://www.ashlink.com).<sup>®</sup>

## 4.6 Trillium Provider Responsibilities

### Responsibilities of Primary Care Physician

The PCP is responsible for coordinating and managing member care and:

- Provides all of the member's primary healthcare services;
- Provides or arranges for healthcare for the member 24 hours a day, seven days a week;
- This includes sufficient call-share coverage so that members may access the PCP or his/her call-share at any time, during or after regular office hours. Members are instructed to contact their PCP before obtaining care;
- Contacts Trillium to obtain prior authorizations in a timely manner, per the prior authorization process;
- Provides member referrals to specialists as medically necessary;
- Reviews information from the specialist and incorporates it in the member's medical record;

- Agrees to accept as his/her patients those eligible members as determined or required by Trillium in order to assure that members have access to primary care services;
- Performs all lab and x-ray services either in the office or at the office of a participating practitioner in accordance with Trillium policies;
- Arranges for prior authorization as appropriate for elective hospital inpatient, residential treatment facility, home health and other services in advance. Specialists may also request prior authorizations;
- Is responsible for the training and education of individuals working within the medical practice to assure that the procedures for coordinated care delivery are followed correctly;
- The PCP will 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).

It is the responsibility of the PCP and the specialist together to ensure that the referral or prior authorization process is completed correctly. The PCP and the specialist will be faxed a hard copy of the referral or prior authorization when it is approved. Specialists must advise the PCP if follow-up treatment is necessary.

### **Responsibilities of Specialists and Behavioral Health Practitioners**

When a member requires treatment that the PCP determines would best be provided by a specialist or behavioral health practitioner, the PCP will provide a referral to a participating specialist/behavioral health practitioner.

For specialists, referred members may be seen for two visits, regardless of diagnosis, without prior authorization. After two visits, if the member requires additional visits and the patient diagnosis remains non-funded according to the [OHA Prioritized List](#), a Prior Authorization request must be submitted through the [Trillium Provider Portal](#) or by [fax request](#). The PCP and the specialist/behavioral health practitioner will be faxed a hard copy of the prior authorization when it is approved.

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

For Behavioral Health Practitioners, referred members may be seen by practitioners for the Behavioral Health Assessment, and ongoing behavioral health services as allowed by the [Trillium Prior Auth Check Tool](#).

Specific Specialist and Behavioral Health Practitioner responsibilities include:

- It is not the member's responsibility to obtain a referral, prior authorization, or authorization number before receiving services from a specialist/behavioral health practitioner.
- Working with the PCP to ensure that the referral or prior authorization process is completed correctly.
- Advising the PCP if follow-up treatment is necessary
- Obtaining proper prior authorization if the member requires a service for which prior authorization is required;
- Notifying the member when the requested service has been approved;
- Ensuring that treatment and services provided are documented and incorporated into the member's primary care medical record as medically necessary;
- Educating and training all individuals working within their medical practice to ensure that Trillium coordinated care procedures and policies are followed correctly.

### **Accepting Enrollees**

Participating providers subject to the agreement between Trillium and the respective Plan, agree to be open to accept new enrollees or closed to accept new enrollees of each and every Plan with which Trillium has

contracted and with which the provider has agreed to participation across each category of contract products such as Medicare and OHP, accepted by Trillium under its agreement with the Plan.

Provider shall provide Trillium with a minimum of 60 days written notice of the intent to close his or her practice to all new patients.

### Accessibility of Practitioners

To ensure that Trillium members have access to medically appropriate healthcare services and that DMAP, CMS, NCQA and other regulatory standards are met, practitioners shall provide timely care in the manner below:

#### PCPs and Specialists

Type of Care	Type of appointment and calls	Schedule timeframe
Primary Care	Urgent care	Within 48 hours of presentation or request
	Routine appointments	Within 30 calendar days
	After hours calls	<ul style="list-style-type: none"> <li>• By medical staff directly;</li> <li>• By an answering service that could reach an on-call provider within 30 minutes;</li> <li>• By a recorded or automated message that has both emergency instructions and a way to reach medical staff</li> </ul>
Specialty Care	Routine appointment	Within 45 calendar days

#### Behavioral Health Practitioners

Type of Care	Type of appointment and calls	Schedule timeframe
Behavioral Healthcare	Non-life-threatening emergency care	The member shall be seen within 6 hours or as indicated in initial screening, or directed to the crisis center
	Urgent care	The member shall be seen within 48 hours or as indicated in initial screening
	Initial visit for routine care	The member shall be seen for an intake assessment within 10 business days from date of request
	Follow-up Routine Care	Non-prescribers: within 14 calendar days Prescribers: within 90 calendar days
	After hours calls	<ul style="list-style-type: none"> <li>• By medical staff directly;</li> <li>• By an answering service that could reach an on-call provider within 30 minutes;</li> <li>• By a recorded or automated message that has both emergency instructions and a way to reach medical staff</li> </ul>

## Dental Health Practitioners

Type of Care	Type of appointment and calls	Schedule timeframe
Dental Care	Routine care	Within 90 calendar days

## All Practitioners

- Have provisions for patients with visual and/or hearing impairments (e.g., a signing interpreter);
- Have procedures for obtaining translation services for members who need them;
- Meet ADA standards for accessibility, including:
  - Easy wheelchair access;
  - Elevators operable from wheelchairs (if elevators are at the site);
  - Easy wheelchair access to exam rooms;
  - Easy wheelchair access and handrails in restrooms.

## Availability of Practitioners

Participating providers agree to provide 7-days-a-week, 24-hour per day coverage for all members. The practitioner or call share practitioner will be available on a 24-hour basis to provide care or to direct members to the most appropriate treatment setting.

A recorded message directing the member to contact the local emergency room is not sufficient to meet this requirement.

Providers must have an adequate telephone answering system or service to ensure member access to the practitioner or call share practitioner after hours.

Telephone answering systems, which use recorded messages, should provide the following information:

- Office hours;
- Why the office is closed (vacation, holiday, after hours) and when the office will reopen;
- If the office is checking messages, the answering system should state so and identify how often;
- The name and telephone number of the on-call practitioner;
- Complete instructions on how to contact the on-call practitioner.

The message should be checked frequently to ensure that the information is accurate and that the message is clear and easily understood.

Telephone answering services must be supplied with accurate information that includes:

- The name of the on-call practitioner and how he/she may be reached;
- When the provider office will reopen;
- Any additional instructions the member needs in order to contact the on-call practitioner.

The answering service should also be able to identify the following:

- When a member should be referred immediately to the emergency room;
- When the PCP or call-share should be notified immediately;
- When a member may leave a message for the provider office to return a call when they return to the office.

Practitioners must return telephone calls from members within a reasonable length of time. The length of time should be appropriate to the member's stated condition. Telephone calls from other practitioners requesting approval to treat a member must be evaluated promptly to determine appropriate action. Urgent calls from members shall be returned appropriate to the member's condition but in no event more than 30 minutes after receipt of the call. Emergent calls from members shall be returned immediately.

Participating providers agree to provide appropriate backup as a component of the triage system. When possible, backup should be provided by a participating practitioner with the same level of training and specialty.

During normal business hours, participating practitioners must have a health professional available to triage urgent care needs and emergencies for members who either walk-in or telephone.

Credentials of a person who triages such needs include:

- Certified Nurse Midwife
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Licensed Practical Nurse
- Behavioral Health Practitioners

## 4.7 Provider Call Coverage Requirements

### Call Coverage

Trillium providers are required to demonstrate that 24-hour coverage is available to their patients. Patients, emergency rooms, and other providers must have the ability to reach the provider or the provider's covering physician.

Exceptions to these criteria may be granted based on specialty need or geographic location in order to satisfy access to care and business requirements.

### Call Share

Participating Providers shall agree to make arrangements for a covering practitioner when they are unavailable.

A call share group listing must be in place with Trillium. You must notify us of the practitioners who regularly call share with you. Trillium cannot retroactively change call share arrangements, so please notify us in advance of providing services when changes in call share are made.

To ensure continuity of care, the call share practitioner shall document and transmit information to the member's primary care medical record.

If a participating practitioner call shares with a non-participating practitioner, the following is required:

- Trillium must credential non-participating call share practitioners prior to seeing members. Trillium reserves the right to deny non-participating practitioner call share status to any practitioner not meeting our credentialing requirements.
- Non-participating call share practitioners must agree to accept Trillium reimbursement rates as payment in full, and agree not to bill the member for balances.
- Non-Participating call share practitioners must agree to use only Trillium participating hospitals, facilities, and ancillary services providers.

### Non-Participating Provider Call Share Agreements

Providers are expected to provide call share coverage by providers who participate in Trillium's OHP Provider Network. When that is not the case, it is the responsibility of the provider to obtain agreement that the non-Trillium call share provider, when giving care to Trillium OHP members, will abide by Trillium contract terms (including payment amounts) in the same manner as the Trillium participating provider.

Non-participating call share practitioners must agree to follow all Trillium standards for referrals, prior authorizations, and any and all rules, standards and other policies and procedures required by Trillium (Trillium's CCO Agreement), CCO, State and Federal requirements.

### Same Specialty

Call coverage within the same specialty is expected, and exceptions require adequate explanation. In rural areas, coverage by providers in different specialties may be necessary. In such cases, the provider should arrange for colleagues in the same specialty to be available to the covering provider for phone consultation and to accept patients in referral, if necessary.

In urban areas, the limited number of specialists available in some sub-specialties may justify coverage by colleagues in related specialties.

## 4.8 Practices on Emergency and 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 information is insufficient to determine the nature of the call, the call must be responded to within 60 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 Care Coordination Workforce at (541) 762-9090, who will work with the member's caseworker, the practitioner and other agencies as necessary and appropriate.

### **Trillium Care Coordination Workforce**

Trillium's Care Coordination team assists practitioners and members with a variety of services including member education, health education, coordination of care, and case management of complex or catastrophic cases, and other services.

If you believe that you or your patient would benefit from case management, please contact Trillium at:  
Phone: (877) 600-5472

## 5. Trillium OHP Membership

### 5.1 Member Identification

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

Trillium provides this medical Identification card to the member:

<p>Medical Dental Behavioral Health</p>  <p><b>Name:</b> &lt;JOHN SMITH&gt; <b>Medicaid ID#:</b> &lt;123456789101112&gt;</p> <p><b>PROVIDER INFORMATION</b> <b>PCP Start Date:</b> &lt;12/05/2016&gt; <b>Doctor (PCP):</b> &lt;Dr. Jane Doe&gt; <b>DCO:</b> &lt;DCO Name&gt; <b>DCO Phone:</b> &lt;(555) 555-1234&gt;</p> <p><b>PHARMACY INFORMATION</b> <b>RX:</b> Envolve Rx <b>RXBIN:</b> 004336 <b>RXPCN:</b> MCAIDADV <b>RXGRP:</b> RX5461</p>	<p><b>FOR MEMBERS</b>  <b>Member Service:</b> 1(877) 600-5472   TTY: 711   <b>Emergencies:</b> 911  <b>www.TrilliumOHP.com</b></p> <p><b>FOR PROVIDERS</b>  <b>Pre-Authorization:</b> 1(877) 600-5472 <i>This card does not guarantee eligibility or authorization.</i>  <b>Envolve Rx:</b> 1(844) 345-2836 <i>Non-participating providers must obtain prior authorization for all services, except for emergency care.</i>  <b>Vision:</b> 1(844) 353-6874 Payer ID# 56190  <b>Envolve Benefit Options –</b>            PO Box 7548, Rocky Mount, NC 27804</p> <p><b>MEDICAL/BH CLAIMS</b>  EDI Payer  Trillium Community Health Plan – Attn: Claims ID: 68069 PO Box 5030, Farmington, MO 63640-5030</p>
<p>Medical Dental Behavioral Health</p>  <p><b>Name:</b> &lt;JOHN SMITH&gt; <b>Medicaid ID#:</b> &lt;123456789101112&gt;</p> <p><b>PROVIDER INFORMATION</b> <b>PCP Start Date:</b> &lt;12/05/2016&gt; <b>Doctor (PCP):</b> &lt;Dr. Jane Doe&gt; <b>DCO:</b> &lt;DCO Name&gt; <b>DCO Phone:</b> &lt;(555) 555-1234&gt;</p> <p><b>PHARMACY INFORMATION</b> <b>RX:</b> Envolve Rx <b>RXBIN:</b> 004336 <b>RXPCN:</b> MCAIDADV <b>RXGRP:</b> RX5461</p>	<p><b>FOR MEMBERS</b>  <b>Member Service:</b> 1(877) 600-5472   TTY: 711   <b>Emergencies:</b> 911  <b>www.TrilliumOHP.com</b></p> <p><b>FOR PROVIDERS</b>  <b>Pre-Authorization:</b> 1(877) 600-5472 <i>This card does not guarantee eligibility or authorization.</i>  <b>Envolve Rx:</b> 1(844) 345-2836 <i>Non-participating providers must obtain prior authorization for all services, except for emergency care.</i>  <b>Vision:</b> 1(844) 353-6874 Payer ID# 56190  <b>Envolve Benefit Options –</b>            PO Box 7548, Rocky Mount, NC 27804</p> <p><b>MEDICAL/BH CLAIMS</b>  EDI Payer  Trillium Community Health Plan – Attn: Claims ID: 68069 PO Box 5030, Farmington, MO 63640-5030</p>
<p>Medical Dental Behavioral Health</p>  <p><b>Name:</b> &lt;JOHN SMITH&gt; <b>Medicaid ID#:</b> &lt;123456789101112&gt;</p> <p><b>PROVIDER INFORMATION</b> <b>PCP Start Date:</b> &lt;12/05/2016&gt; <b>Doctor (PCP):</b> &lt;Dr. Jane Doe&gt; <b>DCO:</b> &lt;DCO Name&gt; <b>DCO Phone:</b> &lt;(555) 555-1234&gt;</p> <p><b>PHARMACY INFORMATION</b> <b>RX:</b> Envolve Rx <b>RXBIN:</b> 004336 <b>RXPCN:</b> MCAIDADV <b>RXGRP:</b> RX5461</p>	<p><b>FOR MEMBERS</b>  <b>Member Service:</b> 1(877) 600-5472   TTY: 711   <b>Emergencies:</b> 911  <b>www.TrilliumOHP.com</b></p> <p><b>FOR PROVIDERS</b>  <b>Pre-Authorization:</b> 1(877) 600-5472 <i>This card does not guarantee eligibility or authorization.</i>  <b>Envolve Rx:</b> 1(844) 345-2836 <i>Non-participating providers must obtain prior authorization for all services, except for emergency care.</i>  <b>Vision:</b> 1(844) 353-6874 Payer ID# 56190  <b>Envolve Benefit Options –</b>            PO Box 7548, Rocky Mount, NC 27804</p> <p><b>MEDICAL/BH CLAIMS</b>  EDI Payer  Trillium Community Health Plan – Attn: Claims ID: 68069 PO Box 5030, Farmington, MO 63640-5030</p>



## 5.2 Member Verification

### Member Eligibility

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@state.or.us](mailto:dmap.providerservices@state.or.us).

**Should a Trillium member who is not currently assigned a PCP present him/herself for treatment, please contact Member Services at (877) 600-5472 for a PCP assignment to your clinic.**

## 5.3 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.

## 5.4 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. Unsuccessful attempts to reach patients should be noted and alternative options should be offered if the patient arrives at the originally scheduled time.

### Missed Appointments

If practitioners experience any problems with members who fail to show for appointments, this information may be relayed to Trillium Member Services Department at (877) 600-5472. Trillium may be able to assist in educating the member about the need to cancel or reschedule appointments prior to the time of an appointment. The member's medical record must contain documentation regarding missed appointments and all recall efforts made by the practitioner, either by mail or by telephone.

Please contact Trillium if the patient is missing appointments due to lack of transportation or other circumstances which may be remedied by assistance from a third party such as the patient's caseworker.

## 5.5.1 Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations: Providers must be accessible to members 24 hours a day, seven (7) days a week.

- **After hours services**
  - Answering services must meet language requirements
  - Should be able to reach the PCP or other designated medical provider
  - All calls need to be returned within 30 minutes
- **Answering machine**
  - Should be on after business hours
  - Should direct members to call another number to reach the PCP or other designated medical provider
  - A live person should be available to answer the designated phone number; another recording is not acceptable
- **Transferred phone call**
  - Calls can be transferred to another location where a live person will be able to assist and can contact the PCP or another designated medical provider.
  - All calls need to be returned within 30 minutes.

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the member's telephone inquiries on a timely basis
- Prioritizing appointments
- Scheduling a series of appointments and follow-up appointments as needed by a member
- Identifying and rescheduling broken and no-show appointments
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient
- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hours calls should be documented in a written format in either an after-hour call log or some other method and transferred to the member's medical record

*Note: If after-hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.*

Trillium Advantage will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

## 5.6 Member Benefits

### Summary of Member Benefits

Benefits provided to Trillium members are based on the Prioritized List of Health Services, OAR 410-141-0520. To obtain a current listing of the Prioritized List, visit:

<http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List.aspx>

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:

- Diagnosis and screening for all conditions on the prioritized list, even those for which treatment may not be covered
- Primary care services, routine physicals, mammograms, obstetrical care, immunizations, smoking cessation programs and well-child exams
- Specialist services (referral required)
- Hospital services
- Medically necessary transportation
- Family Planning services
- Vision care for pregnant women and members under 20 years of age
- Prescription drugs and ancillary services, such as durable medical equipment
- Hospice care
- Most organ transplants
- Behavioral health treatment services

### **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. For assistance, the member may also call Trillium Member Services at (877) 600-5472;
- Future health indicators that may warrant a repeat diagnostic visit.

### **Excluded Services and Limitations**

Certain services or items are not covered under any program or for any group of eligible members. It is the responsibility of the provider to inform members if certain services are not covered by Trillium. If a member chooses to proceed with a non-funded service, it is the responsibility of the provider to specify the total cost of the service to the member, and have the member sign an OHP Client Agreement formally accepting full financial responsibility for the service.

The OHA Client Agreement is available at [https://aix-xweb1p.state.or.us/es\\_xweb/DHSforms/Served/he3165.pdf](https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3165.pdf)

## **5.7 Membership Policies**

### **Member Rights & Responsibilities**

As Oregon Health Plan participants, Trillium members have certain rights and responsibilities pertaining to their healthcare. 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.

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.

Trillium's OHP Member Rights & Responsibilities are detailed at <https://www.trilliumohp.com/members/oregon-health-plan/for-members/member-rights.html>.

For more information or questions please contact Trillium Member Services at (877) 600-5472.

## **Release of Trillium Members from Medical Care**

A Trillium member may be released from medical care by a participating practitioner when, in the practitioner's professional judgment, it is in the best interest of the patient to do so.

### **A Trillium member may not be released from medical care solely because:**

- The member has a physical or mental disability
- There is an adverse change in the member's health
- The member's utilization of services (either under- or over-utilization)
- The member's mental illness
- The member has requested a hearing
- The member has been diagnosed with end-stage renal disease or placed in a hospice after the date of enrollment
- The member has exercised his/her option to make decisions regarding his/her care

### **A Trillium member may be released from medical care for:**

- Missed appointments, at least three or more. Missed appointments must be documented in the member's medical record. The practitioner must also document that he/she has tried to determine the reasons for the missed appointments and has assisted the member in receiving care
- Disruptive, unruly, or abusive behavior to the point that it seriously impairs the practitioner's ability to furnish services, either to the member or to other patients or members
- Threat of or commission of an act of physical violence directed at a practitioner, the provider's office staff, or other patients in the office or at the site
- Fraudulent or illegal acts, including permitting the use of the member's identification card by others, theft of prescription pads, alteration of prescriptions, theft, or other criminal acts committed on the provider's premises
- Violation of a mutually agreed upon treatment contract for opiate or other controlled substance use

**Trillium members have the right to file an appeal with Trillium when a practitioner releases a member from care.**

## **5.8 Member Medical Care Release Policies**

### **Medical Release Procedures**

In the case of a threat or act of physical violence, or a fraudulent or illegal act, the practitioner 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.

1. The practitioner 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.
2. The practitioner must send a copy of the letter to Trillium

3. During the 30-day period between notification and release, the practitioner will remain responsible to provide acute, urgent or emergent care to the member
4. The practitioner will make medical records available to another practitioner upon receiving a signed release from the member
5. If necessary, Trillium will assign the member to another PCP effective on the first day of the following month

Practitioners should make every effort to resolve problems with members. Practitioners 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 failed appointments before the practitioner may request that the member choose or be reassigned to another PCP.

Trillium may assist practitioners 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.

### **Member Medical Records Access**

Each member has the right to receive a copy of his or her medical record and to request that it be amended or corrected as specified in [45 CFR Part 164](#) (Title 45 of the Code of Federal Regulations (CFR) Part 164.)

### **Preventive Care Services**

Trillium practitioners are expected to implement the "A" recommendations of the [Guide to Clinical Preventive Services](#).

## **5.9 Member Medical Care Access**

### **Members with Physical Disabilities**

Trillium participating practitioners must ensure that healthcare services are accessible to people with disabilities or who have other special needs such as visual or hearing impairment.

### **Members with Visual and/or Hearing Impairment**

Providers and practitioners 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 (800) 600-5472 at least one working day before the appointment.

For urgently needed sign language interpreter services, you may call:

- Accessibility Northwest: (541) 687-1221 for on-site interpretive services
- Linguava: (800) 716-1777

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**

All Trillium health Plans have 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 (800) 716-1777 or [scheduling@linguava.com](mailto:scheduling@linguava.com). 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.

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.

There is no charge to the member for translation services.

## 5.10 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 [DMAP Hysterectomy and Sterilization Procedures Manual](#) 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.

**The DMAP Hysterectomy and Sterilization Procedures Manual can be downloaded from the DMAP Web page at:**

<http://www.oregon.gov/oha/healthPlan/Policies/130rb100114.pdf>

### Hysterectomy and Sterilization Consent Forms

Hysterectomy and Sterilization Consent forms (DMAP forms 741, 742A and 742B) for Trillium members may be obtained from:

<http://www.oregon.gov/oha/healthPlan/Pages/forms.aspx>

#### Consent to Sterilization Forms

**21 years and older:** <http://www.oregon.gov/oha/healthPlan/Pages/forms.aspx>

Spanish: <http://www.oregon.gov/oha/healthPlan/Pages/forms.aspx>

**Ages 15 to 20:** <http://www.oregon.gov/oha/healthPlan/Pages/forms.aspx>

Spanish: <http://www.oregon.gov/oha/healthPlan/Pages/forms.aspx>

See the forms section of the Medical – Surgical Services Supplemental guide for completion and submission specifics at: <http://www.oregon.gov/oha/healthPlan/Pages/policies.aspx>

## 6. Billing, Claims Payment & Authorizations

### 6.1 OHP Billing Manual

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 Claims Department at:

Phone: (877) 600-5472

Mail OHP Claims to:

Trillium Community Health Plan, Attn: Claims

P.O. Box 5030

Farmington, MO 63640-5030

#### 6.1.1 Offsets, Adjustments and Recoupments

Per your provider agreement, Clinic authorizes Trillium to offset any amounts owed by Clinic to Trillium, including all overpayment amounts paid by Trillium to Clinic or Clinic Providers, against amounts owed by Trillium to Clinic. Offsets will be applied by Trillium after notifying Clinic in writing of the amount due, why the offset will be applied, and of Trillium's intent to offset the amount if not paid or appealed in writing within 30 days, or after 60 days of identification of an overpayment amount by Clinic of clinic Provider, whichever is earlier.

### 6.2 Prior Authorization Requests

The [Pre-Auth Check Tool](#) on the For 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-Auth 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.

For SNF Prior Authorizations, fax: (866) 703-0958

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.

## 6.3 Specialist Referrals

OHP members may be referred by their PCP to a contracted specialist without a referral request submitted to Trillium for review, for any diagnosis. The specialist may see a member for two visits, regardless of 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 for two visits, regardless of diagnosis.

After two visits, if the specialist 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.

## 6.4 Advance Directives Policy

Trillium follows federal and state laws requiring members to be informed of their right to make healthcare decisions and execute advance directives. An Advance Directive is a formal document that allows a patient to express and control their healthcare needs at a time when they are unable to make decisions.

Our OHP members are encouraged to complete a Power of Attorney for Healthcare, which is a type of advance directive. To comply with the Federal Patient Self-Determination Act (Section 4751 of OBRA 1991) and Oregon laws (ORS 127.650 and ORS 97.050), it is required that practitioners document prominently in the patient's medical record the existence of an advance directive.

If the member is also a Medicare beneficiary, CMS rules require that documentation must be prominently displayed in the record stating either that an advance directive has been signed and is included in the chart or that an advance directive has not been signed. The lack of an entry stating an advance directive has been signed is inadequate; if an advance directive has not been executed it must be explicitly stated so in a prominent location in the patient's record.

Proof of compliance with the above advance directive requirements is part of the routine medical record review which is a necessary part of recertification for participation on the Trillium practitioner/provider panel.

## 6.5 Chemical Dependency Services

Trillium and DMAP share the goal 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.1 – 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, OMT, Level I, Level II, Level II.5, and Level III. A list of the participating treatment facilities is included in the Trillium Member Handbook/Provider Directory members receive when they are enrolled.

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 Behavioral Health of any care management needs for members. The [Trillium Pre-Auth Check Tool](#) is the most efficient provider resource for pre-authorization requirements. When a PA is needed, Trillium Behavioral Health manages prior authorizations for all alcohol and chemical dependency services. Trillium follows published ASAM and AMH criteria.

Trillium Behavioral Health can be reached by telephone at (877) 600-5472, and by fax at (866) 683-5621.

### **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>.

## **6.6 Fraud and Abuse**

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

The provider shall promptly refer all suspected fraud and abuse, including fraud or abuse by its employees or in the Division administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department's Provider Audit Unit (PAU). Contact information may be found online at:

<http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>.

If the provider is aware of suspected fraud or abuse by an Authority or Department client, the provider shall report the incident to the Department's Fraud Investigations Unit (FIU). Contact information may be found online at

<http://www.oregon.gov/oha/healthplan/Pages/general-rules.aspx>.

The provider shall permit the MFCU, Authority, Department, or law enforcement entity, together or separately, to inspect, copy, evaluate or audit books, records, documents, files, Health Plans, and facilities, without charge, as required to investigate an incident of fraud or abuse. When a provider fails to provide immediate access to records, OHP payments may be withheld or suspended.

Providers and their fiscal agents shall disclose ownership and control information and 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.

## 6.7 Subrogation

Provider agrees to subrogate to OHA any and all claims Trillium or the provider has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, DMEPOS, or other products.

## 7. Coordinated Care Team - Overview

### 7.1 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, 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.

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 Plan of care. Clinical Specialists and Medical Management Specialists 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, 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 Assessments (HRA) are available for members to complete online, paper or telephonically. The information gathered from the HRA 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 all healthcare partners and social service agencies. This improves the development of an effective care Plan for the member to assure their physical 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.

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.

Providers may refer their Trillium members into any care coordination services program at by calling (877) 600-5472, or via the [Trillium Provider Portal](#).

## **Care Transitions**

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

- Re-hospitalization
- ED visits
- Disconnection from their medical home
- 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.

Prior authorizations for skilled nursing facilities can be faxed to: 1-866-703-0958

## **Care Plans**

Care Plans are developed within Trillium's shared care Plan program. Communication and coordination with the PCP and available community resources is 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.

## 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.

## Member Connections Representatives (MCRs)

Member Connections Representatives (MCRs), previously 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, 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. Additional information for MCR referrals is available by calling (877) 600-5472.

## 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.

***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

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

## 8. Quality Management

### 8.1 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 improvement initiatives 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 system incorporates a continuous cycle for assessing the level of care and service for members through initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. 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.

Trillium will arrange for the delivery of appropriate care with the primary goal being to improve the health status of its members. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Trillium QMI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

#### QMI Program Structure

The Trillium Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The BOD assigns accountability of the QMI Program to the Quality Improvement Committee (QIC). QIC membership is comprised of Trillium Medical Directors, Vice President-, and Director-level staff as well as practitioners and Quality office staff from Trillium's provider panel.

The purpose of the QIC is to:

- Look for opportunities to transform the quality of care for Trillium members
- Identify areas of improvement within the organization
- Function as quality leaders to ensure information regarding improvement is dispersed and implemented among staff, then communicated back to QIC as necessary
- Promote safe clinical practices and delivery of care to ensure member safety, including clinical guidelines and criteria
- Provide feedback and education to peers regarding status of quality management initiatives

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 Quality Improvement (QI), Utilization Management (UM), and Credentialing and Re-credentialing programs.

#### Practitioner Involvement

Trillium recognizes the integral role that practitioner involvement plays in the success of its QMI Program. Practitioner 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.

#### Quality Management Program Goals and Objectives

Trillium's integrated medical, behavioral, and oral healthcare model is committed to Continuous Quality Improvement (CQI) to conduct meaningful activities internally and externally to ensure members receive care to improve their health and well-being. A focus on and attitude toward improving processes to enhance the quality of outcomes is embedded in Trillium's mission and promoted to reflect how Trillium conducts internal and external business. QMI Program activities include review and evaluation of medical, behavioral, and oral

healthcare members receive. The QMI Program is structured to monitor, analyze, process and implement quality measures internally and externally to improve outcomes and the overall health of the community.

Trillium's commitment to the integrated model is reflected in the following objectives:

- Build and promote quality throughout Trillium's organizational structure, processes and practitioner/provider community
- Promote member safety through monitoring data, collaborating with practitioners, evaluating qualifications and clinically appropriate decision-making and educating members on clinical safety and healthcare programs
- Ensure timely access to appropriate healthcare services, availability of services, second opinions, and that cultural needs and preferences are considered
- Ensure members receive quality care in a culturally and linguistically appropriate manner
- Ensure access to services for members with special or complex medical and/or behavioral healthcare needs
- Ensure member and provider satisfaction
- Maintain compliance with state and federal regulatory requirements and accreditation standards

## **Performance Improvement Process**

The Trillium QIC reviews and adopts an annual QMI Program and Work Plan based on managed care industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Trillium to monitor improvement over time.

Annually, Trillium develops a QMI Work Plan for the upcoming year. The QMI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting, and studies from clinical and service areas of the organization and includes timelines for completion and reporting to the QIC, as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QMI Work Plan.

Trillium communicates activities and outcomes of its QMI Program to both members and providers through avenues such as the member newsletter, provider newsletter, and the [Trillium website](#).

At any time, Trillium providers may request additional information on the health Plan programs including a description of the QMI Program and a report on Trillium's progress in meeting the QMI Program goals by contacting the Quality Improvement department at (877) 600-5472.

## **Patient Safety and Level of Care**

Patient Safety is a key focus of the Trillium QMI Program. Monitoring and promoting patient safety is integrated throughout many activities across the Plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member.

Trillium employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential level of care issues. Adverse events may also be identified through claims-based reporting and analyses. Potential level 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 level of care issues received in the QI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

## 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:

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

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. Measures 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 Review Post Hospitalization, 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.

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:

Phone: (877) 600-5472

Email: [hedis\\_coordinator@trilliumchp.com](mailto: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:

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

## 8.2 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 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 an external review on a Trillium action under the Administrative Procedure Act.

The expression of a complaint, grievance, concern, or appeal may be in whatever form of communication or language that is used by the member or member's representative, and may be made either verbally or in writing. 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 they can access 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 (05/14)). 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 external review request forms available to members.

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  
PO Box 11740  
Eugene, OR 97440-3940

## **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.

Complaint 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 practitioner with the member's written consent, or the legal representative of a deceased member's estate.

The member or the member's representatives also have the right to request a DMAP Administrative Hearing in lieu of Trillium's appeal process. All denial Notices of Action sent by Trillium include information on how to request an appeal or a DMAP Administrative Hearing.

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 and, 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. Forms are located on the Trillium website, or contact Trillium's Member Services department at (877) 600-5472 for assistance.

## **Provider and Practitioner Complaints, Appeals and Grievances**

A provider or practitioner may file a verbal or written complaint against a member, another provider, practitioner, vendor, or Trillium.

Complaints against a Trillium staff member from a provider, practitioner or vendor are forwarded by the GAC to the staff member's supervisor and to Human Resources, as appropriate, for follow-up and resolution.

Member appeal rights are determined by the Oregon Administrative Rules (OAR 410-141-3230, 410-141-3235, 410-141-3245 through 410-141-3248).

## **Provider Claim Disputes and Reconsiderations**

Participating providers agree to adhere to Trillium Community Health Plan Appeals and Grievances procedures as outlined in the *Provider Participation Agreement*.

Providers have the opportunity to request that the Plan reconsider an adverse claim decision. This request should be completed via the Provider Dispute process. The Provider Claim Dispute Form can be found on the Trillium Community Health Plan Website under [\*Provider Resources\*](#). All corrected claims, requests for reconsideration or claim disputes must be received within 180 calendar days from the date of the Explanation of Payment (EOP).

Completed forms and attachments should be mailed to:

Trillium Community Health Plan, Attn: Disputes  
P.O. Box 5030  
Farmington, MO 63640-5030

Trillium Community Health Plan shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 45 business days of receipt of the corrected claim, request for reconsideration or claim dispute.

### **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.

## 9. Glossary of Terms

**Accident:** A sudden, unforeseen bodily injury caused directly by external trauma, which requires immediate medical treatment. Care must begin within 24 hours of the time of the accident.

**Administrative Hearing:** A DHS hearing related to a denial, reduction, or termination of benefits, which is held when requested by the OHP member. A hearing may also be held when requested by an OHP member who believes a claim for services was not acted upon with reasonable promptness or believes the payer took an action erroneously.

**Advance Directive:** A form that allows a person to have another person make healthcare decisions when he/she cannot make the decision and tells a practitioner that the person does not want any life sustaining help if he/she is near death.

**Adverse Event:** An unexpected occurrence which adversely affects the quality of life, quality of care or quality of service for a member. Adverse events include, but are not limited to, death, serious physical or psychological injury, or avoidable admissions or readmissions.

**Aged:** Individuals who meet eligibility criteria established by the Senior and Disabled Services Division (SDSD) for receipt of medical assistance because of age.

**Alternative Care Settings:** Sites or groups of practitioners that provide care to OHP members under contract with the Fully Capitated Health Plan. Such settings include but are not limited to urgent care centers, hospices, birthing centers, out-placed medical teams in community or mobile healthcare facilities, and outpatient surgical centers.

**Americans with Disabilities Act (ADA):** Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

**Ancillary Services:** Those medical services under the Oregon Health Plan not identified in the definition of a Condition/Treatment Pair under the OHP benefit package, but Medically Appropriate to support a service covered under the OHP benefit package. A list of ancillary services and limitations is identified in OAR 410-141-0520, Prioritized List of Health Services, or specified in the Ancillary Services Criteria Guide.

**Appeal:** Any of the procedures that deal with the review of adverse actions on the healthcare services a member believes he or she is entitled to receive, including a reduction in services or delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the member) or on any amounts the member must pay for a service. These procedures include reconsideration by Trillium and/or a DMAP Administrative Hearing.

**Authorization:** Approval obtained by care providers from Trillium Community Health Plan for a designated service before the service is rendered. Used interchangeably with preauthorization and prior authorization.

**Benefit:** A covered service; one that a health insurance Plan will pay for.

**Blind:** Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

**Call Share:** An agreement for practitioners to provide back-up coverage for each other.

**Capitation:** A reimbursement system in which an organization, a group of practitioners, or a practitioner is paid a set amount for a defined set of services on a per member per month basis.

**Capitated Services:** All medically necessary services and supplies rendered or furnished by an organization, group of practitioners, or provider for a capitation payment.

**Capitation Payment:** A predetermined per member per month payment to an organization, group of practitioners, or provider for covered services for each member served by that organization, group of practitioners, or provider.

**Care Coordination Nurses:** A specialized case management service provided by Trillium to DMAP members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405. Care Coordination Nurse services include: early identification of those DMAP members who are Aged, Blind or Disabled that have disabilities or complex medical needs; assistance to ensure timely access to practitioners and capitated services; coordination with practitioners to ensure consideration is given to unique needs in treatment Planning; assistance to practitioners with coordination of capitated services and discharge Planning; and aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

**Case Management:** The process whereby a healthcare professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Case managers reduce the costs associated with the care of such patients, while helping them access high-quality medical services.

**Chemical Dependency Services:** Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent members and their family members or significant others,

**Claim:** (1) A bill for services, (2) a line item of a service, or (3) all services for one recipient within a bill.

**Comfort Care:** The provision of medical services or items that give comfort and/or pain relief to an individual who has a terminal illness. Comfort Care includes the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as possible given the nature of the illness.

Comfort Care includes, but is not limited to, care provided through a hospice program, pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort care includes nutrition, hydration and medication for disabled infants with life-threatening conditions that are not covered under Condition/Treatment Pairs. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

**Community Standard:** Serves as the basis for the expectations of the healthcare delivery system in a member's community.

**Comorbid Condition:** A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient.

**Complaint:** Any expression of dissatisfaction made orally or in writing. Complaints can be expressed by both members and providers.

**Condition/Treatment Pair:** Diagnoses described in the International Classification of Diseases Clinical Modifications, 10th Edition (ICD-10-CM) and the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th Edition (CPT-4) or American Dental Association Codes (CDT-2) or Mental Health and Developmental Services Division Medicaid Procedure Codes and Reimbursement Rates which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

**Coordination of Benefits (COB):** A method of integrating benefits payable under more than one group health insurance Plan so that the insured's benefits from all sources do not exceed 100 percent of allowable medical expenses.

**Credentialing:** A process of investigation and verification of, at a minimum, a practitioner's education, license status, clinical affiliations, and practice history. The credentialing process is intended to verify the quality and integrity of a practitioner's panel for Plan members, employers, and NCQA.

**Department of Human Services (DHS):** DHS is made up of three program areas: Children, Adults and Families; Health Services; and seniors and People with Disabilities. They are supported by the Director's Office; Administrative Services; and Finance and Policy Analysis. The Division of Medical Assistance Programs and the Office of Mental Health and Addiction Services are part of the Health Services Cluster.

**Diagnosis:** The determination of the nature and circumstances of a disease or condition.

**Diagnostic Services:** Those services required to diagnosis a condition, including but not limited to, radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and practitioner or other professional diagnostic or evaluative services.

**Disabled:** Individuals who meet eligibility criteria established by the Senior and Disabled Services Division for receipt of medical assistance because of a disability.

**Disenrollment:** The procedure of dismissing individuals or groups from their enrollment with a carrier.

**Division of Medical Assistance Programs (DMAP):** The office of the Department of Human Services responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration and, Cover All Kids, the Children's Health Insurance Program (CHIP). DMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of member eligibility and processes and pays DMAP providers.

**Dual Eligible:** OHP members who are receiving both Medicaid and Medicare benefits.

**Durable Medical Equipment (DME):** Crutches, wheelchairs, hospital beds, or other therapeutic devices or equipment that can be repeatedly used, are medically necessary, and are not merely for the comfort or convenience of the member or practitioner, but are related to the covered medical condition of the member.

**Emergency Services:** The healthcare and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or with respect to a pregnant woman, the health of both the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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

**Fully Capitated Health Plan (FCHP):** An organization that contracts with the Office of Medical Assistance Programs (DMAP) to provide a full range of medical services, including practitioner, inpatient, outpatient, pharmacy, chemical dependency and ancillary services to members under the regional Oregon Health Plan. Lane Oregon Health Plan is a Fully Capitated Health Plan.

**Grievance:** Any oral or written complaint, other than one involving an action (appeal), expressing dissatisfaction with the manner in which Trillium or a delegated entity provides healthcare services, regardless of whether any remedial action can be taken. Grievance issues may include treatment that did not meet accepted standards for delivery of healthcare. Grievances may also include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.

**Grievance System:** The overall system that includes Complaints and Appeals handled by Trillium and access to the state fair hearing process. (Possible subjects for Grievances include but are not limited to the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a practitioner or employee, or failure to respect the DMAP member's rights.)

**Health Insurance Portability and Accountability Act (HIPAA) of 1996:** HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce healthcare fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

**Hospice Services:** A public or private agency or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

**Line Items:** Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the Oregon Health Plan.

**Medical Assistance Program:** A program for payment of healthcare provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, Cover All Kids and the Children's Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Division of Medical Assistance Programs (DMAP), of the Department of Human Services. Coordination of the Medical Assistance Program is the responsibility of the Division of Medical Assistance Programs.

**Medical Emergency:** The sudden, severe and unforeseen onset of illness or accidental bodily injury that would jeopardize the person's life or health if immediate medical care were not received.

**Medical Group:** A group of practitioners organized as a single professional entity that is recognized under state law as an entity to practice a medical profession, and has entered into a contract to provide covered services to members.

**Medically Appropriate:** Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are: consistent with the symptoms of a health condition or treatment of a health condition; appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective; not solely for the convenience of an Oregon Health Plan member or a practitioner of the service or medical supplies; and the most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an DMAP member in the judgment of the FCHP or Primary Care Practitioner.

**Non-Covered Services:** Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but NOT covered under the Oregon Health Plan. Non-covered services for the Oregon Health Plan are identified in: OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan members; exclusions and limitations described in OAR 410-120-1200; and individual practitioner administrative rules as published by the Office of Medical Assistance Programs.

**Oregon Health Plan (OHP):** The Medicaid demonstration project which expands Medicaid eligibility to eligible Oregon Health Plan members and Cover All Kids, which expands Oregon's safety net capacity to connect undocumented immigrant children and teens (under 19) to primary/preventive health care. The Oregon Health Plan relies substantially upon prioritization of health services and coordinated care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

**Oregon Health Plan (OHP) Plus Benefit Package:** A benefit package available to eligible Oregon Health Plan members as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-120-0520, Prioritized List of Health Services.

**Oregon Health Plan (OHP) Standard Benefit Package:** A benefit package available to eligible Oregon Health Plan members who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-141-0520, Prioritized List of Health Services.

**Pre-existing Condition:** Physical condition of an insured person that existed before the issuance of a policy or enrollment in a Plan. Pre-existing conditions may result in a limitation in the contract on coverage or benefits.

**Preventive Services:** Those services as defined under Expanded Definition of Preventive Services for Oregon Health Plan members in OAR 410-140-0480, the Oregon Health Plan Benefit Package of Covered Services, and OAR 410-141-520, Prioritized List of Health Services.



**Primary Care Practitioner (PCP):** A participating practitioner chosen by the member or assigned by the FCHP to have responsibility for supervising and coordinating initial and primary healthcare within his/her scope of practice for that member. A PCP initiates a referral for care outside his/her scope of practice, consultations and specialist care, and assures the continuity of medically appropriate care.

**Prior Authorization:** An approval process prior to the provision of services, usually requested by the provider or practitioner, also may be called Preauthorization.

**Prioritized List of Health Services:** The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

**Quality Assurance (QA):** The process, which ensures that healthcare services received by our members, meet accepted standards of care in the community.

**Quality Improvement:** Those activities conducted by Trillium to ensure that healthcare services received by members meet accepted standards of care in the community. Quality Improvement as defined in Oregon Administrative Rules includes the goals of quality assurance, quality control, quality Planning and quality management in healthcare where “quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.”

**Referral:** A referral is considered a request to the Plan for authorization of services as listed on the prior authorization list. PCPs are not required to issue *paper* referrals, but are required to direct the member’s care and must obtain a prior authorization for referral to all non-emergent out-of-network practitioners as noted on the Plan prior authorization list. Referral is not required for all in-network specialty providers.

**Representative:** A person who can make Oregon Health Plan-related decisions for OHP members who are not able to make such decisions for themselves. A representative may be, in the following order of priority: a person who is designated as the Oregon Health Plan member’s healthcare representative; a court appointed guardian; a spouse or other family member as designated by the Oregon Health Plan member; the Individual Service Plan Team (for developmentally disabled members); a DHS case manager or other DHS designee.

**Resource-Based Relative Value Scale (RBRVS):** A financing mechanism that reimburses healthcare practitioners on a classification system.

**Second Opinion:** A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member’s health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner, if there is no in-network practitioner available. The second opinion is provided at no cost to the member.

**Self-Insured:** Management in which providers or practitioners deliver health services, but the member’s employer not the insurance company covers the cost of these services.

**Senior and People with Disabilities (SPD):** The Division of DHS responsible for providing services such as assistance with long-term care, cash assistance grants for persons with long-term disabilities, and administration of the federal Older Americans Act.

**Solo Practice:** Individual practice of medicine by a provider or practitioner who does not practice in a group or share personnel, facilities, or equipment with other practitioners.

**Specialist Practitioner/Provider:** A Practitioner or provider whose training and expertise are in a specific area of medicine.

**Standards of Care and Service:** Standards that have been developed by the Oregon Medical Assistance Program (for the Oregon Health Plan), the Centers for Medicare and Medicaid Services (CMS), the National

Committee for Quality Assurance (NCQA), and from medical group practice accreditation programs as well as Plan progress.

**Subrogation:** When healthcare costs of enrollees are the responsibility of an entity other than the insurer, such as workers' compensation, third party negligence liability or automobile medical coverage.

**Terminal Illness:** An illness or injury in which death is imminent irrespective of treatment, and where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

**Triage:** Evaluations conducted to determine whether or not an emergency condition exists, and to direct the member to the most appropriate setting for Medically Appropriate care.

**Urgent Care Services:** Covered services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of a member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services.

**Utilization and Quality Management (UM):** The Health Plan department that is primarily responsible for ensuring efficient utilization of resources and monitoring quality of care.

**Valid Claim:** An invoice received by the FCHP for payment of covered healthcare services rendered to an eligible DMAP member which: can be processed without obtaining additional information from the provider or practitioner of the service or from a third party; has been received within the time limitations prescribed in Oregon Administrative Rules. A valid claim is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

## 10.0 Acronyms

Acronym	Meaning	Definition
<b>ABAD</b>	Aged, Blind and Disabled	A Medicaid category for individuals with special needs
<b>ACT</b>	Assertive Community Treatment	A full range of services for people who have been diagnosed with a serious mental illness. ACT's goal is to give patients adequate community care and to empower patients to live independently in the community.
<b>APM</b>	Alternative Payment Model	A payment for efficiency or quality outcomes rather than services.
<b>ASC</b>	Ambulatory Surgery Center	Medical facilities that specialize in elective same-day or outpatient surgical procedures.
<b>BAA</b>	Business Associate Agreement	A contract between a HIPAA-covered entity and a HIPAA business associate (BA). The contract protects health information in accordance with HIPAA guidelines.
<b>BH</b>	Behavioral Health	Concerning mental health and substance use disorders
<b>BMMH</b>	Behavioral Health Medical Home	A behavioral health clinic with embedded primary care
<b>BOD</b>	Board of Directors	Trillium CCO Board provides leadership and governance in the achievement of the Triple Aim: better health, better care and lower cost. Our board members are a diverse group representing every area of healthcare.
<b>CAC</b>	Community Advisory Council	The council is intended to engage consumers throughout Lane County in improving the way their health needs and the health needs of their community are being met.
<b>CAHOOTS</b>	Crisis Assistance Helping Out on the Streets	Mobile crisis intervention 24/7 that provides immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy & (in some cases) transportation to the next step in treatment.
<b>CAK</b>	Cover all Kids	Coverage for children who are undocumented immigrants
<b>CAM</b>	Complementary and Alternative Medicine	Health care practices that traditionally have not been part of conventional medicine, such as acupuncture, massage, or music therapy
<b>CAP</b>	Clinical Advisory Panel	A committee engaging providers in the region to build networks of care that enhance patient outcomes consistent with the goals of the Triple Aim
<b>CCO</b>	Coordinated Care Organization	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 the Oregon Health Plan
<b>CFD</b>	Center for Family Development	A clinic providing outpatient mental and chemical dependency treatment, as well as integrated primary care
<b>CHC</b>	Community Health Center	Organizations that provide primary health services and related services to residents of a defined geographic area that is medically underserved
<b>CHCLC</b>	Community Health Center of Lane County	Lane County's CHC
<b>CHIP</b>	Community Health Improvement Plan	A long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process.
<b>CHNA</b>	Community Health Needs Assessment	A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.
<b>CHW</b>	Community Health Worker	A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

<b>CM</b>	Case Management	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
<b>CMS</b>	Centers for Medicare and Medicaid Services	A federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid
<b>CMT</b>	Collective Medical Technologies	The company that created EDIE and PreManage
<b>CNC</b>	Centene	Centene's stock name
<b>COB</b>	Coordination of Benefits	The process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute
<b>CPT</b>	Current Procedural Terminology	A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations
<b>DCO</b>	Dental Care Organization	Like a CCO, DCOs contract with oral health providers, process claims, provide care coordination and utilization management
<b>DHS</b>	Department of Human Services	The principal agency for "protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves." Also known as DHHS and HHS
<b>DME</b>	Durable Medical Equipment	Any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses
<b>DOS</b>	Date of Service	The date a member received a service
<b>DRG</b>	Diagnostic Related Group	A statistical system of classifying any inpatient stay into groups for the purposes of payment
<b>DSN</b>	Delivery Service Network	The network of service providers contracted with the CCO
<b>DSNP</b>	Dual Special Needs Plan	DSNPs enroll beneficiaries who are entitled to both Medicare and Medicaid
<b>EC</b>	Executive Committee	A CCO committee that provides organizational oversight and direction on behalf of the Board, acts on the Board's behalf and request, and exercises the power of the Board with respect to management of the Company
<b>ED</b>	Emergency Department	A medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance
<b>EDI</b>	Electronic Data/Document Interchange	The computer-to-computer exchange of business documents in a standard electronic format between business partners
<b>EDIE</b>	Emergency Department Information Exchange	Software that links hospital registration systems real-time
<b>EDW</b>	Enterprise Data Warehouse	A unified database that holds all the business information an organization and makes it accessible all across the company
<b>EHR</b>	Electronic Health Record	A digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users
<b>EMR</b>	Electronic Medical Record	A digital version of a patient's paper chart. EMRs are real-time, patient-centered records that make information available instantly and securely to authorized users
<b>EQR</b>	External Quality Review	The analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services provided by a CCO
<b>ETG</b>	Episode Treatment Group	A classification system that combines related services or claims into clinically homogenous units that describe complete episodes of care

<b>FFS</b>	Fee for Service	A payment model where services are unbundled and paid for separately
<b>FQHC</b>	Federally Qualified Health Center	Community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas
<b>FTE</b>	Full Time Employee	An employee employed on average at least 30 hours of service per week, or 130 hours of service per month
<b>FUSE</b>	Frequent User Systems Engagement	A program identifying frequent users of jails, shelters, hospitals and/or other crisis public services and then improving their lives through supportive housing
<b>FWA</b>	Fraud Waste and Abuse	Varying degrees of misuse of government funds
<b>G&amp;A</b>	Grievances and Appeals	Expressions of dissatisfaction with providers, the plan or decisions made about care
<b>GOBHI</b>	Greater Oregon Behavioral Health Inc	An organization that contracts with several CCOs to administer behavioral health benefits
<b>HBR</b>	Health Benefits Ratio	A metric used to measure medical costs as a percentage of revenues
<b>HCPCS</b>	Healthcare Common Procedural Coding System	Often pronounced by its acronym as "hick picks," HCPCS is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set	A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service
<b>HHS</b>	Health and Human Services	The principal agency for "protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves." Also known as DHHS and HHS
<b>HIE</b>	Health Information Exchange	Allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically
<b>HIPAA</b>	Health Insurance Portability and Accountability Act	A federal law that, among other things, requires that patient medical information be kept private and secure and that standardizes electronic transactions involving health information
<b>HITAG</b>	Health Information Technology Advisory Group	An OHA meeting where CCOs advise on health information technology-related matters
<b>HITOC</b>	Health Information Technology Oversight Council	An OHA committee tasked with setting goals and developing a strategic health information technology (HIT) plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan
<b>HMA</b>	Health Management Associates	A consulting firm for Centene, Trillium and OHA
<b>HRA</b>	Health Risk Assessment	A survey or questionnaire used to collect relevant information about the health status and health risk factors of an individual
<b>HRS</b>	Health Related Services	Non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being
<b>ICCM</b>	Intensive Community Case Management	A case management program helping members with five or more conditions, of which one is behavioral.
<b>ICD</b>	International Classification of Diseases	A system used by physicians and other healthcare providers to classify and code all diagnoses
<b>IP</b>	Inpatient	Admitted to the hospital for treatment
<b>IPCS</b>	Independent Primary Care Services	A group of independent clinics in Lane County that share a contract, an EHR and other administrative functions
<b>ISCA</b>	Information Systems Capability Assessment	Determination of whether a CCO maintains a health information system that can accurately and completely collect, analyze, integrate, and report data on member and provider characteristics, and on services furnished to members

<b>JOC</b>	Joint Operating Committee	A quarterly meeting with provider groups to monitor performance, both financially and clinically
<b>LCBH</b>	Lane County Behavioral Health	The behavioral health clinic for the Lane County CHC
<b>LCOG</b>	Lane Council of Governments	The Metropolitan Planning Organization for the central Lane County area that includes the Eugene-Springfield metropolitan area and Coburg
<b>LILA</b>	Lane Independent Living Alliance	A non-residential, consumer-controlled organization serving people with physical, mental, cognitive, and sensory disabilities
<b>LIPP</b>	Lane Independent Primary Physicians	A former group of independent clinics in Lane County that shared a contract, an EHR and other administrative functions
<b>LOB</b>	Line of Business	Type of product (Medicaid, Medicare, Commercial, etc.)
<b>LTC</b>	Long Term Care	A continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities
<b>MDC</b>	Major Diagnostic Category	A method of dividing all possible principal diagnoses into 25 mutually exclusive diagnosis areas corresponding to a single organ system or etiology and in general associated with a particular medical specialty
<b>MH</b>	Mental Health	Concerning mental health only - does not include substance use disorders
<b>MM</b>	Member Months	The number (and percent) of months a member or members were enrolled with the plan
<b>MOU</b>	Memorandum of Understanding	A nonbinding agreement between two or more parties outlining the terms and details of an understanding, including each parties' requirements and responsibilities
<b>MPC</b>	Major Procedure Category	A system for rolling up procedures by type and specialty
<b>NAMI</b>	National Alliance on Mental Illness	A nationwide grassroots advocacy group, representing people affected by mental illness in
<b>NCQA</b>	National Committee for Quality Assurance	An accreditation group that works to improve health care quality through the administration of evidence-based standards, measures and programs
<b>NDC</b>	National Drug Code	A unique 10-digit, 3-segment numeric identifier assigned to each medication that identify the labeler or vendor, product, and trade package
<b>NEMT</b>	Non-Emergency Medical Transportation	Transportation to non-emergent services, such as doctors' appointments and pharmacies
<b>NPI</b>	National Provider Identifier	A unique 10-digit identification number issued to health care providers in the United States by CMS
<b>NQTL</b>	Non-Quantitative Treatment Limits	Non-numerical benefit limits on the scope or duration of benefits for treatment (such as preauthorization requirements)
<b>OH</b>	Oral Health	Related to the teeth
<b>OHA</b>	Oregon Health Authority	The entity in Oregon that administers the Oregon Health Plan
<b>OHP</b>	Oregon Health Plan	Oregon's state Medicaid program
<b>OHPB</b>	Oregon Health Policy Board	The nine-member Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority
<b>OIG</b>	Office of Inspector General	A federal department charged with identifying and combating waste, fraud, and abuse in the HHS's more than 300 programs
<b>OIH</b>	Oregon Integrated Health	A clinic offering traditional medical and behavioral services as well as complimentary or alternative care
<b>OMG</b>	Oregon Medical Group	A primary care group in Lane County that takes Medicaid only

<b>OP</b>	Outpatient	Using the hospital for treatment without being admitted
<b>P4P</b>	Pay for Performance	A payment model where providers are given financial incentives for meeting performance objectives. P4P is also known as value-based payment (VBP)
<b>PA</b>	Prior Authorization	A process used to determine if the plan will cover a prescribed procedure, service, or medication
<b>PCMH</b>	Primary Care Medical Home	A care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand
<b>PCP</b>	Primary Care Physician	A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions
<b>PCPCH</b>	Patient Centered Primary Care Home	A care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand
<b>PDMP</b>	Prescription Drug Monitoring Program	A state-run program which collects and distributes data about the prescription and dispensation of federally controlled substances
<b>PH</b>	Physical Health	Services related to physical care, rather than behavioral or oral care
<b>PHI</b>	Protected Health Information	Any information in a medical record that can be used to identify an individual, and that was created, used, or disclosed in the course of providing a health care service, such as a diagnosis or treatment
<b>PHMG</b>	Peace Health Medical Group	A physician and hospital group
<b>PII</b>	Personally Identifiable Information	Any data that could potentially identify a specific individual
<b>PMPM</b>	Per Member Per Month	Applies to a revenue or cost for each enrolled member each month. The number of units of something divided by member months
<b>PNM</b>	Provider and Network Management	The Trillium department that handles contracting, credentialing, provider relations and provider data management
<b>PPO</b>	Preferred Provider Organization	A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network
<b>QAPI</b>	Quality Assessment/Performance Improvement	The coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI)
<b>QHOC</b>	Quality and Health Outcomes Committee	OHA's forum for communication of the clinical and quality aspects of implementation of the Oregon Health Plan
<b>QI</b>	Quality Improvement	A framework to systematically improve the ways care is delivered to patients. Processes have characteristics that can be measured, analyzed, improved, and controlled
<b>QM</b>	Quality Management	Overseeing all activities and tasks needed to maintain a desired level of excellence
<b>QTL</b>	Quantitative Treatment Limits	benefit Limitations which are numerical in nature (such as visit limits)
<b>RAC</b>	Rural Advisory Council	The CCO committee tasked with engaging Trillium Community Health Plan Members and the community as a whole in the rural areas of Lane County to advise and make recommendations to the governing Board on the strategic direction of the organization
<b>RFA</b>	Request for Applications	A type of solicitation notice in which an organization announces that grant funding is available. An RFA informs researchers and other organizations that they may present bids on how the funding could be used

<b>RFP</b>	Request for Proposal	A document that solicits proposal, often made through a bidding process, by an agency or company interested in procurement of a commodity, service, or valuable asset
<b>ROI</b>	Return on Investment	The ratio between the net profit and cost of investment resulting from an investment of some resources. A high ROI means the investment's gains compare favorably to its cost
<b>Rx</b>	Prescription	An instruction written by a medical practitioner that authorizes a patient to be provided a medicine or treatment
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration	The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation
<b>SDOH</b>	Social Determinants of Health	The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors
<b>SDS</b>	Senior and Disability Services	The Area Agency on Aging (AAA), and the Medicaid long-term care agency for Lane County
<b>SFP</b>	Springfield Family Physicians	A physician group in Springfield
<b>SFTP</b>	Secure File Transfer Protocol	A network protocol that provides secure file access, file transfer, and file management over any reliable data stream
<b>SNP</b>	Special Needs Plan	A Medicare Advantage coordinated care plan specifically designed to provide targeted care and limit enrollment to special needs individuals
<b>SPMI</b>	Severe and Persistent Mental Illness	Individuals with schizophrenia and other psychotic disorders, major depression and bipolar disorders, anxiety disorders, schizotypal personality disorder or borderline personality disorder
<b>SUDs</b>	Substance Use Disorders	A condition in which the use of one or more substances leads to a clinically significant impairment or distress
<b>TANF</b>	Temporary Assistance for Needy Families	A program that provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical
<b>TAT</b>	Turn Around Time	The elapsed time between receipt and payment of a claim
<b>TBH</b>	Trillium Behavioral Health	The behavioral health organization for Trillium's CCO
<b>TCOC</b>	Total Cost of Care	All direct and indirect costs associated with an episode of care for a period of health care coverage
<b>THW</b>	Traditional Healthcare Worker	Frontline public health workers who work in a community or clinic under the direction of a licensed health provider: Community Health Workers, Personal Health Navigators, Peer Support Specialists, Peer Wellness Specialists and Birth Doulas
<b>TIIP</b>	Trillium Integration Incubator Project	The pilot project, started in 2012, that integrated behavioral and physical health care via co-location, care coordination and systems integration
<b>TIN</b>	Tax ID Number	An identifying number used for payment and tax purposes
<b>TIP</b>	Trillium Integration Project	The continuation of TIIP in subsequent years following the pilot
<b>TJR</b>	Total Joint Replacement	A surgical procedure in which parts of an arthritic or damaged joint are removed and replaced with a prosthesis
<b>TPL</b>	Third Party Liability	Insurance that protects the first party (the policyholder) from legal liability to a third party (the other person / property involved)



<b>TPR</b>	Third Party Recovery	Claims that are the responsibility of someone other than Trillium. The responsible party may be a person, firm, corporation, or insurance company. Auto-related injuries and “slip-and-fall” injuries are examples of common third party cases
<b>TQS</b>	Transformation and Quality Strategy	An OHA-required plan to move health transformation forward to meet the triple aim of better health, better care and lower costs
<b>UC</b>	Urgent Care	A category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department
<b>VBP</b>	Value Based Payment	a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes rather than FFS
<b>WFT</b>	Willamette Family Treatment	A behavioral health clinic with embedded primary care
<b>WH</b>	Withhold	A percentage of a provider's contract rate that is retained by Trillium during claims adjudication and paid at a later time if performance targets are met by the provider



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