Yamhill
Community Care
Provider Handbook
2025

Updated May 1, 2025

Contents

Welcome to Yamhill Community Care (Yamhill CCO)

Yamhill Community Care (Yamhill CCO) is a nonprofit coordinated care organization dedicated to managing the healthcare for Medicaid Members, covered under the Oregon Health Plan, in Yamhill County, as well as parts of Washington and Polk Counties. Our mission is to improve the quality of life of the communities we serve by coordinating effective care. Beyond healthcare, we also provide an Early Learning Hub, supporting families and children with essential resources and programs for early childhood development. Together, we are building a unified healthy community that celebrates physical, mental, emotional, spiritual, and social well-being.

The Yamhill CCO Provider handbook is a resource that contains information on your responsibilities as a Yamhill CCO network Provider, health plan benefit information, and required policies and procedures. Should you be contracted with one of our partners, you may be held to additional standards contained in their contracting process and an additional Provider manual or handbook.

What is Yamhill CCO?

Vision

- A unified health community that celebrates physical, mental, emotional, spiritual, and social well-being.

Mission

- Working together to improve the quality of life and health of the Yamhill Community by coordinating effective care.

Guiding Principles

- Health Education
- Accountability
- Innovation
- Evidence-Based Clinical Care
- Transparency
- Shared Responsibility
- Member Empowerment
- Wellness Promotion
- Equity
- Stewardship

What is a Coordinated Care Organization?

A Coordinated Care Organization (CCO) is a network of Providers that coordinate the physical (medical), behavioral, and dental health care services of Medicaid or Oregon Health Plan (OHP)

Members within their communities. The goal of CCOs is to meet the “Triple Aim” of better health, better care, and lower costs for the populations they serve. CCOs are focused on prevention and helping people manage chronic conditions. This work helps reduce unnecessary hospitalizations, emergency room visits, and diagnostic testing and gives people support to be healthy. Yamhill CCO collaborates closely with local Providers to achieve these goals.

What is Oregon Health Plan?

The Oregon Health Plan (OHP) is the Medicaid program in Oregon. Medicaid is a health care program paid for by federal and state dollars to provide eligible, low-income Oregonians basic health care services through programs administered by the Oregon Health Authority (OHA).

OHP covers medically necessary and appropriate services including but not limited to doctor visits, prescriptions, hospital stays, dental care, mental and behavioral health services, and help with addiction to tobacco, alcohol, and drugs. OHP can provide hearing aids, wigs, medical equipment, home health care, and transportation to health care appointments.

- Doctor visits
- Primary care
- Lab and x-ray
- Prescription drugs
- Pregnancy care
- Hospital visits
- Medical equipment
- Dental cleanings
- Mental health care
- Some vision services

Additional services such as transportation assistance and non-billable services and supplies may also be covered by Yamhill CCO.

Key Contacts and Information

Contact	Focus Area
Yamhill Community Care Administrative Office: Physical Location: 807 NE Third Street McMinnville, OR 97128 Office Hours: Monday – Friday 8:00am-4:30pm PST Mailing Address: Yamhill CCO PO Box 5490 Salem, OR 97304 Phone: 855-722-8205 TTY 711 Office Email: Info@Yamhillcco.org	Executive Team Finance Legal Our offices are wheelchair accessible.
Yamhill CCO Customer Service: Phone: 855-722-8205 TTY 711 Monday – Friday 8:00am-5:00pm PST	All inquiries
Claims Phone: 855-722-8205 TTY 711 Email: Yamhillclaims@ayin.com Mailing Address: Yamhill CCO PO Box 5490 Salem, OR 97304	Claims inquiries Billing issues Payment methodology inquiries
Member Grievance and Appeals Phone: 971-345-5933 or 833-257-2192 TTY 711 Fax: 503-765-9675 Email: Appeals@Yamhillcco.org	Member appeals and complaints
Provider Grievance and Appeals Phone: 971-345-5933 Fax: 503-765-9675 Email: Provider.Appeals@Yamhillcco.org	Provider appeals/reconsiderations Contact Customer Service if inquiring on contracted rate payment of a claim-do not file a reconsideration.

Case Management and Care Coordination Phone: 971-345-5932 Fax: 503-607-8336 Email: Caremanagement@Yamhillcco.org	Integrated Care Coordination Flex Funds
Utilization Management (UM) Phone: 855-722-8205 TTY 711 Fax: 503-850-9398 Email: UtilizationManagement@Yamhillcco.org CIM Portal	Medical and Behavioral Health Utilization Review (Prior Authorizations)
Quality Improvement Email: Qualityimprovement@Yamhillcco.org	CCO Quality Metrics Quality Improvement
Compliance Phone: 503-455-8058 Email: Compliance@Yamhillcco.org Compliance & FWA Hotline (can report anonymously) Or Phone: (844) 989-2845	Compliance Fraud, Waste, and Abuse (FWA)
Contracting Email: Providercontracting@Yamhillcco.org	Contracting new Providers and facilities Contractual questions regarding terms of contract Out of State DMAP enrollment
Credentialing Email: credentialing@Yamhillcco.org	Credentialing services Credentialing Committee Provider Credentialing rights Reporting changes in Professional Liability Coverage Roster changes
Provider Relations Email: Providerrelations@Yamhillcco.org	Provider information changes Facility/Clinic information updates Traditional Health Workers Provider Network Communications Provider Trainings Provider Education Additional Provider assistance Yamhill CCO programs and services DMAP enrollment assistance Network requests

WellRide – transdev Phone: 844-256-5720 TTY 711 Monday – Friday 7:30 am-6:00 pm	Non-emergent medical transportation
Pharmacy Phone: 503-574-7400 or 877-216-3644 Fax: 503-574-8646 or 800-249-7714 Prior Auth via Electronic PA: • CoverMyMeds • Surescripts	Drug Coverage and Pharmacy Services
Behavioral Health Phone: 855-722-8205 Email: YamhillCCObh@Yamhillcco.org	Behavioral Health Services
Substance Use Disorder Resources **Yamhill County:** Wraparound or IIBHT Phone: 503-434-7462 Crisis Hotline: 1-844-842-8200 or 988 **Polk County:** Wraparound or IIBHT Phone: 503-400-3500 Crisis Hotline: 1-888-552-6642 or 988 **Washington County:** Wraparound or IIBHT Phone: 503-846-4528 Crisis Hotline or IIBHT Phone: 503-400-3350 or 988 **Substance Use Disorder Referral Network** **(Behavioral Health Resource Network)** Phone: 503-434-7462	Yamhill, Polk and Washington County based SUD services
Health Related Social Needs Phone: 971-345-5932 Fax: 503-850-9398 Email: hrsnteam@Yamhillcco.org	Climate-device, nutrition, housing Support
Dental – Capitol Dental Care Phone: 800-525-6800 TTY 711 Hours: Monday – Friday 8:00 am-5:00 pm	Dental Customer Service and Prior Authorization (go to Capitol Dental Website)
Imaging PA Through eviCore	Prior Authorization for imaging services

Phone: (800) 918-8924 Yamhill CCO prior approval list Evicore website for PA submission	
Durable Medical Equipment Phone: 503-215-4663	All durable medical equipment questions
Early Learning https://yamhillearlylearning.org/ Phone: (503) 376-7421 Email: **earlylearning@Yamhillcco.org**	Early learning resources and services
FamilyCore Phone: (971) 261-1912 Email: **earlylearning@Yamhillcco.org**	FamilyCore referrals and program assistance
Language Access **Passport to Languages** Phone: 503-297-2707 Fax: 503-297-1703	Language support services
Electronic Payer ID Information 855-722-8205 TTY: 711 Monday-Friday 8:00am-5:00pm PST	Contact Yamhill CCO Customer Service

Glossary of Terms

A

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Yamhill CCO or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to Yamhill CCO.

Access: Ability to obtain medical services.

Americans with Disabilities Act (ADA): Prohibits discrimination against people with disabilities in employment, transportation, public accommodation, and communications. The ADA also establishes requirements for TTY relay services.

Adjudication: Processing a claim through a series of edits to determine proper payment.

Ancillary Services: Covered services necessary for diagnosis and treatment of Members. Includes, but is not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy, urgent or emergency care, and other covered service customarily deemed ancillary to the care furnished by primary care or Specialist Providers. For the OHPs, ancillary services are those medical services not identified in the definition of a condition/ treatment pair under the OHP Benefit Package but are medically appropriate to support a service covered under the OHP Benefit Package. A list of ancillary services and limitations are identified in OAR-410-141-0520, Prioritized List of Health Services.

Appeal: A request for review of an adverse benefit determination (ABD) initiated by the Member. A Provider can represent a Member in an appeal but must have written authorization from the Member to do so. A Provider-initiated appeal without Member written authorization is called a reconsideration.

Adverse Benefit Determination (ABD): The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner pursuant to 410-141-3515; the MCE's failure to act within the Time frames provided in 410141- 3875 through 410-141-3895 regarding the standard resolution of grievances and appeals; for a resident of a rural area with only one MCE (Managed Care Entities), the denial of a Member's request to exercise their legal right under §438.52(b)(2)(ii) to obtain services outside the network; or the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Assessment: The determination of a Member’s need for Covered Services. It involves collection and evaluation of data pertinent to the Member’s history and current problem(s) obtained through interview, observation, and record review.

B

Beneficiary: A person who has health care insurance through the Dual-Eligible or Medicaid programs.

Benefit Package: Specific services covered by the OHP, OAR 410- 141-0480 and OAR 410-120-1210 including diagnostic services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.

C

Case Management Services: Specialized coordination of care services provided by Yamhill CCO and its Providers for severe or complex health care problems or for care not available locally.

CCO (Coordinated Care Organization): A local health plan that manages health services. All CCOs have a network of health care Providers, such as doctors, nurses, counselors and more.

Chemical Dependency: The addictive relationship with a drug or alcohol characterized by either a physical and/or psychological relationship that interferes with the individual's social, psychological, or physical adjustment to common problems on a recurring basis. For purposes of this definition, chemical dependency does not include addiction to or dependency of tobacco, tobacco products, or foods.

Claim: A request for payment that you submit to Medicare or other health insurance plans when you provide items and services that you think are covered.

Clinical Advisory Panel (CAP): A committee comprised of physical, behavioral, and oral health Providers charged with assuring best clinical practices and conducting quality improvement activities for Yamhill CCO.

CMS 1500 Form: A federal agency with the Department of Health & Human Services (DHS) responsible for Medicare and Medicaid programs.

Coordination of Benefits (COB): A method of determining who has primary responsibility when there is more than one payer available to pay benefits for the same medical claim.

Complaint/Appeal: A request by a Yamhill CCO Member or a Member's representative to review an adverse benefit determination. For this policy, an appeal also includes a request by Yamhill CCO to review an adverse benefit determination.

Condition/Treatment Pair: Conditions described in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (ICD-10- CM) and treatments described in the Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) which, when paired by the HERC, constitute the line items in the Prioritized List of Health Services. Condition / Treatment Pairs may contain many diagnoses and treatments. The Condition / Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

Contractor: Any entity that provides services to Yamhill CCO pursuant to the terms of a written agreement. Additionally for the purposes of this plan, the term contractor includes subcontractors with whom the contractor subcontracts work relating to Medicaid plans.

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

D

Delegated Entity: Any entity that Yamhill CCO determines meets the definition of a first tier, downstream, or related entity.

Denied Claims: A denied claim is a claim that has been received and processed. An explanation of benefits (EOB) is sent to the Provider indicating the reason for denial.

Department of Human Services (DHS): Oregon's principal agency for helping Oregonians achieve wellbeing and independence through state funded assistance programs.

Diagnostic Services: Those services required to diagnose a condition, including but not limited to, radiology, ultrasound, other diagnostic imaging, EKGs, laboratory, pathology, examinations, and physician or other professional diagnostic/evaluative services.

Disenrollment: The formal leaving of a managed care plan or other health coverage program; the termination of a Member or group's Membership in a health plan.

Dismissal: When a Member is removed from a clinic or medical practice following specific guidelines established by Yamhill CCO and in accordance with established OHA guidelines.

Durable Medical Equipment (DME): Crutches, wheelchairs, hospital beds, or other therapeutic equipment which stand repeated use, are medically necessary, and are not merely for comfort or convenience of the Member or Provider. The equipment must be related to the covered medical condition of the Member.

E

Emergent/Emergency: 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: (a) Placing their health or the health of an unborn child in serious jeopardy; (b) Serious impairment of bodily functions; or (c) Serious dysfunction of any bodily organ or part. "Immediate medical attention" is defined as medical attention which cannot be delayed by 24 hours.

Employee: Any full time, part time, or temporary employee of Yamhill CCO who works directly or indirectly on Medicaid plans. Additionally, for the purposes of this plan, the term employee includes Yamhill CCO volunteers who work directly or indirectly on Medicaid plans.

Enrollment: The process of enrolling Members in a health plan.

Explanation of Benefits (EOB): A form included with a reimbursement check from Yamhill CCO that explains benefits paid and/or charges that were denied.

F

Fee-for-Service (FFS): A reimbursement system in which a Provider bills Yamhill CCO for each service after the service has been provided.

Formulary: List of approved prescription medications. Also called a drug list.

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

G

Global Fee: A single fee that is billed and paid for all necessary services normally furnished by the Provider before, during and after a procedure.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievances include the Member's right to dispute an extension proposed by the Yamhill CCO to make an authorization decision.

H

Health Evidence Review Commission (HERC): Reviews clinical evidence in order to guide the Oregon Health Authority in making benefit-related decisions for its health plans. Its main product is the Prioritized List of Health Services, used by the legislature to guide funding decisions for the Oregon Health Plan.

Health Insurance Portability and Accountability Act (HIPAA): The "Standard for Privacy of Individually Identifiable Health Information (also called the "Privacy Rule")" of HIPPA assures all health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Hospice: A healthcare service that provides supportive care for the terminally ill. Hospice care involves a team-oriented approach that addresses the coordinated care of the Member. Hospice also provides support to the Member's family or caregivers.

I

Incident: A situation of possible fraud, waste, and/or abuse which has the potential for liability for Yamhill CCO or Yamhill CCO's contracted delegates and/or contractors.

In-network: Providers, including hospitals and pharmacies, that have agreed to provide Members of certain insurance plan with services or supplies at a contracted rate. In some insurance places, Member care is only covered if it is received from an in-network Provider.

K

Knowingly: as defined in 31 U.S.C §3729(b) means that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

L

Living Will: A written, legal document, also called a "medical" or "advance directive" that shows what type of treatment a Member wants in the event they cannot speak for themselves. This document usually only comes into effect if they are unconscious.

M

Managed Care: A system of care where a company contracts with the Oregon Health Authority to provide care under guidelines for Members assigned to manage the cost, quality, and access of care. It is characterized by a contracted panel of physicians and/or Providers; use of a primary care practitioner; limitations on benefits provided by non- contracted physicians and/or Providers; and a referral authorization system for obtaining care from someone other than the primary care practitioner.

Medicaid: The joint federal and state program for some U.S. citizens with low-income and limited resources.

Medically Appropriate: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare: A federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Member: A person entitled to receive benefits under a policy or contract issued, arranged, or administered by Yamhill CCO. With respect to actions taken regarding grievances and appeals,

references to a “Member” include, as appropriate, the Member and/or the Provider or the Member’s representative with written consent, and the legal representative of a deceased Member’s estate.

N

Non-Covered Services: Health care services or items for which Members are not entitled to receive from Yamhill CCO according to the Plan Benefit as outlined in the Oregon Health Plan (OHP) Benefit Contract. Services may be covered under OHA but not covered under OHP. Non-covered services for the OHP are identified in OAR 410- 120-1200 (excluded services and limitations), or in the individual OHA Provider Guides.

Non-Participating Provider: A Provider who has not signed a contract with Yamhill CCO.

O

Open Card Member: A person found eligible by DHS division to receive services under the OHP. The individual may or may not be enrolled with Yamhill CCO.

Oregon Health Authority (OHA): A division of the Department of Human Resources responsible for the administration for the Federal/State Medicaid Program and the Oregon Health Plan Medicaid Demonstration Project (OHP).

Oregon Health Plan (OHP): The Medicaid demonstration project which expands Medicaid eligibility to low-income residents and to children and pregnant women up to 185% of the federal poverty level. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

Out-of-Area: Any area that is outside the Yamhill CCO service area.

Out-of-Network Provider: A Provider who is not contracted with Yamhill CCO as a part of the panel.

P

Participating Provider: A Provider who has signed a contract with Yamhill CCO.

Potential: If, in one’s professional judgement, it appears as if an incident of fraud or abuse may have occurred, the standard of judgement used would be that judgement exercised by a reasonable and prudent person acting in a similar capacity.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests (e.g., Pap tests) and immunizations.

Preventive Services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (e.g., Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP): A Provider selected by a Member who shall have the responsibility of providing initial and primary care and for referring, supervising, and coordinating the provision of all other covered services to the Member. A PCP may be a family Provider, general practitioner, internist, pediatrician, or other practitioner or nurse practitioner who has otherwise limited their practice of medicine to general practice or a Specialist who has agreed to be designated as a primary care practitioner. Managed care plans require that each enrollee be assigned to a PCP who functions as a gatekeeper.

Primary Hospital: The hospital which has signed a contract with Yamhill CCO to provide covered hospital services for its Member. Capitation payment may be the method of reimbursement for the hospital.

Prior Authorization (PA): An approval process prior to the provision of services, usually requested by the Provider for procedures, admissions, or services before the services are provided. Factors determining authorization may be eligibility, benefits of a specific plan, or setting of care.

Provider Panel: Participating Providers contracted with a plan to provide services or supplies to Members.

Q

Quality Assurance Program: A program and process that is carried out by Yamhill CCO and contracted Providers to monitor, maintain, and improve the quality of services provided to Members.

Quality Improvement (QI): A continuous process that identifies problems in healthcare delivery, tests solutions to those problems, and monitors the solutions for improvement. A process that assures that health care received by Members meets accepted community standards of care.

R

Reconsideration: A request for review of an adverse benefit determination (ABD) initiated by the Provider without Member written authorization.

Referral: A written order from a Provider to see a Specialist or get certain medical supplies or services. If a referral is not acquired, the health insurance plan may not pay for the service.

Representative: A person who can make OHP-related decisions for OHP Members who are not able to make such decisions themselves. A representative may, in the following order of priority, be a person who is designated as the OHP Client’s health care representative, a court appointed guardian, or a spouse or other family Member designated by the OHP Member. The Individual Service Plan Team (for developmentally or behaviorally disabled Members) or a DHS case manager designated by the OHP client can also serve as Representatives.

Risk: A possibility that the revenues of the insurer will not sufficiently cover expenditures incurred in the delivery of contractual services.

S

Service Area: The geographic area covered by the health insurance plan where direct services are provided. A plan may disenroll a Member if they move out of the health insurance plan's service area.

Subcontractor: Any individual, entity, facility, or organization, other than a participating Provider, which has entered a Subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.

Supplier: Any company, person, or agency that gives a medical item or service, except when the Member is in a hospital or skilled nursing facility.

T

Telehealth: Telemedicine and the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or Member and professional health-related education, public health, and health administration.

Third Party Administrator (TPA): An independent person or corporate entity that administers group benefits, claims, and administration for a self-insured group or insurance company. A TPA does not underwrite risk.

Third Party Resource (TPR): A medical or financial resource that under law is available and applicable to pay for medical services and items for a medical assistance client.

Triage: The classification of sick or injured persons, according to severity, in order to direct care and ensure efficient use of medical and nursing staff and facilities.

TTY (Teletypewriter): A special device which connects to a standard telephone used for people who are deaf, hard of hearing, or have speech loss to communicate with a hearing person.

U

Urgent: A medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychological suffering by the patient. An urgent admission is defined as one which could not have been delayed for a period of 72 hours.

Utilization: The extent to which the Members of a covered group use a program over a stated time, specifically measured as a percentage determined by dividing the number of covered individuals who submitted one or more claims by the total number of procedures of a particular healthcare benefit plan.

Utilization Review: The review of health care services for medical necessity, efficacy, quality of care, cost effectiveness, and coverage under the Prioritized List of Health Services.

Utilization Management: The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes also called “utilization review.”

V

Verbal abuse: Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

W

Waste: Overutilization or inappropriate utilization of services and misuse of resources and typically is not criminal or intentional.

Provider Services

All obligations of the Participating Provider Agreement, general principles, responsibilities, and procedural protocol set forth in the preceding sections of the manual apply when serving Yamhill CCO Members. In addition, Yamhill CCO is required to meet contract requirements specified by the Oregon Health Authority (OHA) for Coordinated Care Organizations. The delivery of medical services to Yamhill CCO Members must conform to OHA policies, procedures, rules, and interpretations in the following order of precedence:

1) Federal law, regulation, and waivers granted OHA by CMS to operate the OHP
2) Oregon state law;
3) Oregon Administrative Rules and OHA General Rules;
4) Any other duly promulgated rules issued by OHA and other offices and divisions within the Department of Human Resources necessary to administer the OHP.

OHA furnishes individually enrolled OHA Providers with the OHA Provider's Handbook for Medical-Surgical Services and the CMS-1500 Billing Guide and any current OHA Service Guide(s) specific to the Provider's category of service. The documents establish service and billing procedures and are to be used in conjunction with the current OHA General Rules and Oregon Health Plan Administrative Rules. To order OHA forms/publications and to determine OHA Provider enrollment status, go to the OHA website.

Provider Rights

Providers have the right to:

- Receive information from Yamhill CCO regarding treatment and utilization patterns for the Members served and know how the Provider compares with peers.
- Disagree with Yamhill CCO reviews and/or decisions that affect the treatment or care of Members, or that endanger the Provider's professional standing as a participating Provider and be heard through a formal appeal process.
- Be reviewed and evaluated by a panel of peers on issues of clinical practice.
- Be treated courteously by Yamhill CCO Members.
- Be supported by Yamhill CCO in educating Members about Member responsibilities.
- Expect prudent and responsible fiscal management of Yamhill CCO business.
- Expect prudent and responsible fees for Provider services.
- Have timely and accurate adjudication of claims for services rendered.
- Receive timely payment from Yamhill CCO.
- Be informed of Yamhill CCO administrative rules, policies, and standards of practice.
- Not be discriminated against based on Provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or Members in whom Provider specializes.

Provider Responsibilities

Providers have the responsibility to:

- Provide competent, compassionate, and individualized quality care to Yamhill CCO Members within the scope of the Provider's practice and profession.
- Provide care in a manner that is respectful and considerate of the Members' unique needs.
- Be knowledgeable of Yamhill CCO administrative rules, policies, and standards of practice.
- Be informed of Member rights and responsibilities and respect these rights and responsibilities.
- Provide information so that a Member can give informed consent for Member treatment. Fully disclose to the Member treatment options not covered by Yamhill CCO that may be of benefit to the Member. Obtain consent from an appropriate surrogate or health care representative if the Member is unable to participate in decision-making.
- Give priority to clinical and scientific considerations over financial considerations.
- Adhere to Yamhill CCO Clinical Practice Guidelines or, where the Provider judges the standards not to be in an individual Member's interest, advocate another treatment option to Yamhill CCO.
- Work with Yamhill CCO to meet Transition of Care requirements per OAR 410-141-3850 for Yamhill CCO Members.
- Participate in a timely manner with Yamhill CCO in assuring all relevant information in the Provider Directory is accurate.
- Annually attend and participate in Cultural Responsiveness and Implicit Bias training and retain records the training was completed. The training should also be provided to the Provider staff. OHA pre-approved training to meet this obligation can be accessed on OHA's website.
- Encourage and assist Members to make advance directives and assure that directives are honored within the confines of state law.
- Educate and encourage Members to maintain health and to use preventive and early-intervention services.
- Keep confidential all communications and records related to care, except in the case of persons who have a need-to-know because they are participating in the delivery of care, in Medical Management and Quality Management activities, or in resolution of claims or grievances.
- Maintain confidentiality of information about individual Members. Provide information to employers only when permission of the Member is obtained. Follow federal and state privacy regulations, including maintaining an Accounting for Disclosures database which tells Members if their health information has been disclosed inappropriately as required by federal and state regulations.
- Employ reasonable administrative safeguards consistent with the security rules in 45 CFR Part 164 to ensure Member information is used or disclosed in a manner consistent with applicable State and federal laws.
- Be courteous when discussing Yamhill CCO policy or procedures with Yamhill CCO employees or representatives.
- Pursue continuing medical education.
- Issue denial notices or notify Yamhill CCO of a denial, when either a service or referral is not approved.
- Bill and Appeal within timely filing.

- Bill electronically whenever possible.
- Educate and encourage Members to use Yamhill CCO's resources prudently.
- Appropriately utilize the resources allocated by Yamhill CCO.
- Treat Members without regard to the Provider's financial gain or loss when the treatment is appropriate and necessary.
- Participate in the collection of outcome data and quality assurance data.
- Speak out and resist if peers, purchasers, or Yamhill CCO are pursuing unethical practices.
- Protect Member rights while maintaining a professional approach in discussing Yamhill CCO policies and procedures.
- Abide by policies and procedures of Yamhill CCO that are a result of collaborative deliberation of Yamhill CCO and its physician leadership.

Credentialing and Contracting

Yamhill CCO and delegated partners follow all OHA CCO Contract, State, and Federal Rules and has guidelines for all aspects of the credentialing and re-credentialing process, including appropriate verifications, System for Award Management (SAM), and Office of Inspector General (OIG) screenings, credentialing decisions, adverse actions, process timeframes, and notifications. Yamhill CCO will ensure that all practitioners/Providers have legal authority and appropriate training, certification, license, and experience to provide care to Members prior to participation with Yamhill CCO and that the process will be followed for all licensures and by any entities that perform the process on Yamhill CCO's request or behalf. The Yamhill CCO Provider selection policies and procedures do not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment. The Yamhill CCO PN-002 Credentialing Process Policy and Procedure provides additional information pertaining to Yamhill CCO credentialing.

Credentialing Process Overview

Once a Provider has met all requirements for network participation and a contract is issued and signed, the Provider will receive the appropriate Delegated Partner Provider Manual/Handbook as well as the Yamhill CCO Provider Handbook.

Yamhill CCO, in accordance with Oregon Administrative Rule (OAR) 410-141-3510, and in accordance with Coordinated Care Organization (CCO) Contract, require all Providers to complete initial credentialing prior to participation pursuant to Patient Protection and Affordable Care Act (PPACA) Section 6402, 42 Code of Federal Regulation (CFR) §§§ 438.214, 455.400 through 455.470 (excluding § 455.460).

Yamhill CCO's comprehensive Credentialing (CR) Program ensures that its practitioner and Provider network meet the standards of professional licensure and certification as delineated by state, federal, and accreditation requirements. This process enables Yamhill CCO to recruit and retain a quality network to serve its Members and ensure ongoing access to care. The program consistently and periodically assesses and evaluates the ability of practitioners and Providers to deliver quality care

between credentialing and recredentialing cycles, and it emphasizes and supports the Provider's ability to successfully manage the health care of Members in a cost-effective manner.

Providers are initially credentialed and subsequently re-credentialed according to Yamhill CCO's Credentialing Policies and Procedures. Re-credentialing shall take place at least every three (3) years (not to exceed 36 months) to the day. Completion of the credentialing process and approval by the Credentialing Committee is required prior to providing care for Yamhill CCO Members.

Yamhill CCO's credentialing and recredentialing policies and procedures are reviewed at least annually to ensure ongoing compliance and alignment with the National Committee for Quality Assurance (NCQA) standards and guidelines, CCO Contract, OARs, and CFR; however, policies can be reviewed and updated sooner if a change in requirements needs to be reflected in established or new policies. Members of the Credentialing Sub-committee review the CR Program. All employed and contracted practitioners/Providers are subject to the peer review process.

Yamhill CCO requires the following to be submitted and verified as part of the credentialing process:

- Current version of the Oregon Practitioner Credentialing Application (OPCA) (for initial/new credentialing) and the Oregon Practitioner Recredentialing Application (OPRA) (for re-credentialing) approved by the Advisory Committee on Physician Credentialing Information (ACPCI). The application must be complete in order for the credentialing process to begin. This includes the completed Attestation questions, Authorization and Release of Information form, and required additional documents.
- Unrestricted (no limitations), current and valid professional licensure to practice in Oregon, or another state where Yamhill CCO Membership may receive care.
- Current and valid Federal DEA Certificate for practitioners with the authority to write prescriptions for practice. When a practitioner waives their prescriptive authority, or has restricted prescriptive authority, the DEA Form must be completed.
- Preferred Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have an education (Residency) in their practicing specialty. New graduates must become board-certified within five (5) years of completing an approved residency or fellowship training program in their practice area. Board certification requirements may be waived upon review of the CRS if the practitioner has five (5) years of verified work history and/or has unrestricted, active privileges in the specialty area at a participating hospital in their respective service area.
- Current, unrestricted clinical privileges at a participating hospital, if applicable, or evidence of coverage/transfer arrangement with a privileged participating practitioner. Admission arrangements with a hospitalist group within a The Joint Commission or Critical Access hospital is acceptable.
- Acceptable twenty-four (24) hour coverage system. Coverage system should include twenty-four (24) hour telephone coverage and arrangements for alternate care of patients if absence occurs, through another professional practitioner consistent with Yamhill CCO and/or payor's policies, procedures, standards, and/or criteria.
- Acceptable, current, and valid malpractice insurance in the amount $1 million per incident and $3 Million per aggregate per year or as determined satisfactory by the CRS.

- Absence of a history of denial or cancellation of professional liability insurance, involvement in malpractice suits, arbitration, settlement, or evidence that the history does not suggest an ongoing substandard professional competence or conduct.
- Absence of health problems including drug or alcohol abuse, which might hurt judgment or competence, to substantially impede the professional practitioner's ability to perform the essential functions of their practice/profession.
- Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, health care organization, managed care organization, governmental health care program; or evidence this history does not suggest an on-going substandard professional competence or conduct.
- Absence of a history of criminal/felony convictions or indictments or evidence this history does not suggest an effect on professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.
- Seclusion and Restraint Attestation Form
- Additional information may be requested during the credentialing process.

Providers deemed moderate or high risk

The OHA has established categorical risk levels for Providers. OHA is responsible for performing site visits for Provider deemed “moderate” or “high” risk and for ensuring “high” risk Providers have undergone fingerprint-based background checks. For a Provider actively enrolled in Medicare and undergoing a fingerprint-based background check as part of Medicare enrollment, OHA deems this Provider satisfied the same background check requirement for OHA Provider Enrollment.

During the credentialing process Yamhill CCO verifies Provider categorical risk level assigned by OHA. When credentialing Providers or Provider types designated by OHA as “moderate” or “high” risk, Yamhill CCO shall not execute any contract with such Providers unless the Provider has been approved for enrollment by OHA. Yamhill CCO requires all enrolled Providers to permit Centers for Medicare & Medicaid Services (CMS), its agents, its designated contractors, or the OHA to conduct unannounced on-site inspections of all Provider locations. OHA’s Provider Enrollment files are updated weekly and available to credentialing staff to verify the Provider’s enrollment.

For frequently asked questions regarding contracting and credentialing and applicable policies, refer to Yamhill CCO PN-002 Credentialing Process policy.

Delegated Partners

Yamhill CCO and delegated partners follow all OHA CCO Contract, State and Federal Rules and has guidelines for all aspects of the credentialing and re-credentialing process, including appropriate verifications, SAM and OIG screenings, credentialing decisions, adverse actions, process timeframes and notifications. Yamhill CCO will ensure that all practitioners/Providers have the legal authority and appropriate training, certification, license, and experience to provide care to Members prior to

participation with the coordinated care organization and that the process will be followed for all licensures and by any entities that perform the process on Yamhill CCO's request or behalf.

Yamhill CCO Provider selection policies and procedures do not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment. The Yamhill CCO PN-002 Credentialing Process Policy and Procedure provides additional information pertaining to Yamhill CCO credentialing.

Credentialing and contracting may be a delegated function and held by a delegated partners. Below is a list of the partners, their contact information, and the Provider types they work with.

- Dental/Oral Health
  - Telephone: 503-585-5205
  - Email: Providers@capitoldentalcare.com
- Non-Emergent Medical Transportation: 844-256-5720

Once a Provider has met all requirements for network participation and a contract is issued and signed the Provider will receive the appropriate Yamhill CCO Provider Handbook and Provider Training.

Locum Tenens

A Locum Tenens arrangement is made when a participating Provider must leave their practice temporarily due to illness, vacation, leave of absence, or any other reasons. Locum Tenens is a temporary replacement for that Provider, usually for a specified amount of time. Locum Tenens should possess the same professional credentials, certifications, and privileges as the practitioner replaced. Please visit the policy listed below.

When a participating Provider requires coverage by a Locum Tenens Provider, the practice should notify Provider Relations of the arrangements. If the Locum Tenens Provider will be covering for more than 60 days, the Locum Tenens Provider is required to be credentialed. The Provider should email Provider Relations at Providerrelations@Yamhillcco.org.

Locum Tenens Provider Agreement

Locum Tenens Providers shall agree to accept Yamhill CCO payments for participating Providers and not bill the Member for balances other than co-payments.

Use participating Providers and contracted facilities when available.

Follow Yamhill CCO's referral and prior authorization procedures and the policies listed below:

- Yamhill CCO Policy MM-006 Authorization of Services
- Yamhill CCO Policy PN-006 Locum Tenens and Reciprocal Billing

Taxpayer Identification Numbers (TIN)

Providers are required to immediately report any change in the Provider's tax identification number (TIN). To ensure accurate IRS reporting, the tax ID number must match the business name reported to the federal government.

When notifying Yamhill CCO of a change of tax identification number, please follow these steps:

- If a current version of the IRS W9 form is needed, access the form here.
- Complete and sign the W9 form, following instructions exactly as outlined on the form. Include an effective date.
- On a separate sheet of paper, explain the date the new number becomes effective (when Yamhill CCO should begin using the new number).
- Send the completed form with the effective date by fax to 541.440.6306, email Providerrelations@Yamhillcco.org or mail:

  Yamhill Community Care
  Attn: Provider Relations
  807 NE Third Street
  McMinnville, OR 97128

Primary Care Providers

When a Provider chooses to be designated as a Primary Care Provider (PCP) under the OHP, they agree to provide and coordinate health care services for Yamhill CCO Members. The PCP will provide or facilitate referrals to Specialists to provide for the complete healthcare needs of the Member. PCPs are expected to abide by Yamhill CCO's Policy ENR-005 Enrollment and Disenrollment.

PCP responsibilities include:

- Being the Manager of the Member's Care.
- Providing all primary preventive healthcare services except for a yearly gynecological exam for which the Member may choose to seek services from a participating women's healthcare specialist.
- When specialized care is medically necessary, facilitating a referral to a specialist or specialty facility.
- Contacting Yamhill CCO to obtain a referral or PA for a specialist (if required).
- Monitoring the Member's condition and arranging appropriate care when notified of an out-of-area emergency that will require follow-up or has resulted in an in-patient admission.
- Coordinating care and sharing appropriate medical information with Yamhill CCO as well as with a specialist to whom Members are referred.
- Documenting in a prominent place in their Member's records whether an individual has executed an Advance Directive.

- Completing and attaching the Sterilization and Hysterectomy Consent Form to the claim when submitting claims for their Yamhill CCO Members specific to this service.
- Per HIPAA Privacy rule – Providers are responsible for safeguarding Members' personal health information (PHI). Disclosure of any PHI is limited to the minimum necessary and a disclosure form is required prior to any release of PHI.
- Follow Yamhill CCO policy when dismissing a Member from care. Yamhill CCO expects Providers to consider, on an individual basis, whether dismissal is appropriate for the Member. If possible and safe to do so, Providers should attempt to mitigate any behavior in order to maintain the relationship. If a dismissal is necessary, please fax a copy of the letter to Yamhill CCO Customer Care attn: Yamhill CCO 503-315-4134. This will ensure Yamhill CCO can take the appropriate steps needed to provide the Member with continued care while at the same time honoring the Provider's request of dismissal.
- Second Opinion - Yamhill CCO provides for Members to obtain a second opinion at no cost. If a Member wants a second opinion about treatment options, the Member can ask the PCP to refer the Member for another opinion. If the Member wants to see a Provider outside Yamhill CCO's network, the Member or Provider can submit a prior authorization request to Yamhill CCO.

Referral to a Specialist

In cases where referrals to specialists are required to adequately address the medical needs of the Member, the PCP can refer Member's care to a specialist. Yamhill CCO does not require prior authorization (PA) when Members receive services from other in-network specialists. Some services require a PA to see an out-of-network Provider. PA requirements can be found here.

It is not the responsibility of the Member to obtain an authorization from their PCP before receiving services from a specialist. The specialist and PCP together are responsible for completion of the authorization process.

Primary Care Providers (PCP) are always expected to complete an evaluation to ensure appropriate care and intervention, prior to referring to a specialist. Once a PCP evaluation is complete, the in-network or out-of-network specialist will request a PA for consultation, if the services require a PA per the Yamhill CCO PA Grid. The PCP does not need to submit these PA requests.

Process for Initial Specialist Consultation:

- Members will visit their PCP for an initial evaluation to determine if consultation with a specialist is necessary.
- If the PCP determines that a Member needs to see a specialist, the PCP will send a referral (not a prior authorization) to specialist along with chart notes from the initial assessment and visit.
- If the specialist agrees to see a Member, the specialist will submit a prior authorization to Yamhill CCO for an initial consultation, **if the services require a PA.** Documentation of the PCP's referral order and initial evaluation are included with this PA submission.
- Out-of-network specialists always require a PA for services and treatment.

- The specialist may submit a PA for continued visits, **if the services require a PA.** This prior authorization needs to include documentation from the initial consultation with the specialist.

Process for services and ongoing treatment:

If there has been a lapse in treatment (more than one (1) month for therapy services or more than one (1) year for all other treatment) for the same condition, or the Member had been discharged from or denied coverage for treatment, the Member must be re-evaluated by the PCP before the specialist can submit a PA.

If there has been a short lapse in treatment (less than one (1) month for therapy services or less than one (1) year for all other treatment) for the same condition, a re-evaluation with the PCP is not necessary before the specialist can submit a PA.

Specialists have the responsibility to treat Members within the scope of the specialist's practice and coordinate and share appropriate medical information with the Member, the Member's PCP, and Yamhill CCO.

Specialists as PCPs

A specialist may consider being a PCP for an established Member if the specialist is willing to assume all responsibilities of being a PCP. Examples of this include an OB Provider becoming the PCP for a pregnant Member and an Oncologist Provider becoming the PCP for a Member during cancer treatment.

Provider Availability Requirements

Participating Providers agree to accept new Members unless the Provider's practice has closed to new Members. Providers cannot close the Provider's practices to only Members of health plans they deem undesirable. The Provider needs to notify Provider Relations by email at Providerrelations@yamhillcco.org when the Provider's practice is closing to new Members and when the Provider's practice re-opens.

Participating Providers agree to provide 24 hours a day, 7 days a week coverage for Yamhill CCO Members in a culturally competent manner and in a manner consistent with professionally recognized standards of healthcare. The Provider or designated covering Provider will be available on a 24-hour basis to provide care personally or to direct Members to getting the most appropriate action for treatment. All telephone contact with Members shall be recorded and entered into the Member's medical record.

Providers and subcontractors must meet the standards for timely access to care and services as set forth in, OAR 410-141-3515 and OAR 410-141-3860, which includes, without limitation, providing services within a time frame that considers the urgency of the need for services. Primary Care Providers ("PCPs") are required to meet the following availability standards (OAR 410-141-3515(11)(a): i. ii. iii. i. ii.

- Time frame for Urgent Appointments – Within 72 hours or as indicated in initial screening and in accordance with OAR 410-141-3840.
- Time frame for Well Care Appointments – Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OARs 410-141-3860 through 410-141-3870.
- Time frame for referring to Emergency Care – Immediately or referred to an emergency department depending on the Member's condition.
- Specialists are required to meet the following availability standards (OAR 410-141-3515(11)(a)).
- Time frame for Urgent Appointments – Within 72 hours or as indicated in initial screening.
- Time frame for Well Care Appointments – Within four (4) weeks, or as otherwise required by applicable care coordination rules, including OARs 410-141-3860 through 410-141-3870. 18 iii. III. IV. i. ii.
- Time frame for referring to Emergency Care – Immediately or referred to an emergency department depending on the Member's condition.
- Oral and Dental Care Providers are required to meet the following availability standards for children and nonpregnant Members (OAR 410-141-3515(14)(b)):
- Time frame for Emergent Dental Care – Seen or treated within 24 hours as defined in OAR 410-120-0000;
- Time frame for Urgent Dental Care – Within two (2) weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; iii.
- Time frame for Routine Dental Care – Within eight (8) weeks, unless there is a documented special clinical reason that makes a period of longer than eight (8) weeks appropriate.

Oral and Dental Care Providers for pregnant individuals are required to meet the following availability standards for pregnant individuals (OAR 410-141-3515(14)(c)):

- Time frame for Emergent Dental Care – Seen or treated within 24 hours;
- Time frame for Urgent Dental Care – within one (1) week;
- Time frame for Initial Screening or Routine Dental Care – Within four (4) weeks, unless there is a documented special clinical reason that would make access longer than four (4) weeks appropriate.

Behavioral Health Providers are required to meet the following availability standard (OAR 410-141-3515(11)(c)):

- Routine behavioral health care – for non-priority populations: assessment within seven (7) days of the request, with a second appointment occurring as clinically appropriate.
- Urgent behavioral health care for all populations: Within 24 hours
- Specialty behavioral health care for priority populations:
    - In accordance with the time frames listed below for assessment and entry, terms are defined in OAR 309-019-1015, with access prioritized per OAR 309-019-0135. If a time frame is not met due to lack of capacity, the Member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use

disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135;
    - Pregnant women, veterans and the veteran's families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;
    - IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;
    - Opioid use disorder: Assessment and entry within 72 hours;
    - Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;
    - Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance.

Provider Access Requirements

Yamhill CCO shall ensure that its network meets the following time and distance access standards.

Yamhill CCO's in-network PCPs are required to meet the following time and distance standards to ensure 95% of Yamhill CCO Members can access the following Providers and facility types:

- Tier one:
    - Primary care Providers serving adults and those serving pediatrics;
    - Primary care dentists serving adults and those serving pediatrics;
    - Mental health Providers serving adults and those serving pediatrics;
    - Substance use disorder Providers serving adults and those serving pediatrics
    - Pharmacy;
    - Additional Provider types when it promotes the objectives of the Oregon Health Authority or as required by legislation.
- Tier two:
    - Obstetric and gynecological service Providers;
    - The following specialty Providers, serving adults and those serving pediatrics;
        - Cardiology;
        - Neurology;
        - Occupational Therapy;
        - Medical Oncology;
        - Radiation Oncology;

        - Ophthalmology;
        - Optometry;
        - Physical Therapy;
        - Podiatry;
        - Psychiatry;
        - Speech Language Pathology.
        - Hospital;
        - Durable medical equipment;
        - Methadone Clinic;
        - Additional Provider types when it promotes the objectives of the Oregon Health Authority or as required by legislation.
- Tier three: The following specialty Providers, serving adults and those serving pediatrics;
    - Allergy & Immunology;
    - Dermatology;
    - Endocrinology;
    - Gastroenterology;
    - Hematology;
    - Nephrology;
    - Otolaryngology;
    - Pulmonology;
    - Rheumatology;
    - Urology.
    - Post-hospital skilled nursing facilities;
    - Additional Provider types when it promotes the objectives of the Oregon Health Authority or as required by legislation.

Yamhill CCO's geographic designation for its service area falls within OHA's definition of rural. Yamhill CCO monitors its Provider network with the following rural time and distance standards for Providers and facility tiers identified above:

- Tier one: 30 minutes or 20 miles;
- Tier two: 75 minutes or 60 miles; Tier three: 110 minutes or 90 miles.

Covering Providers and On-Call Arrangements

Yamhill CCO and delegates require participating Providers to meet state standards for timely access to care and services considering the urgency of the Member's need for services. Providers should have an after-hours call-in system adequate to triage urgent care and emergency calls from Members. It is essential that Members be able to reach the PCP or on-call Provider at any time. The Provider must have a system in place that allows a Member to be evaluated telephonically by a live person. The evaluator will be able to give the Member clinical advice or to facilitate contact with another individual who has that ability. Additional information related to appointments is located under the Availability of Appointments and Scheduling section.

Coordination of Reassignment

Once a request for reassignment has been approved, Providers are expected to assist in the coordination of care.

- Upon approval of reassignment, the Provider office must inform the Member by mail of the reassignment within two (2) business days of approval.
- Content of the letter to the Member should include:
  - Reason for reassignment, if appropriate.
  - Timeline for reassignment.
    - If possible and safe to do so, Providers should attempt to provide a 30-day or more transition period.
      - In certain situations, a longer transition may be warranted if it is feasible and safe to do so.
      - Shorter transitions may be necessary specifically in situations where safety is a concern (e.g., immediate reassignment).
    - Provider availability during the transition, such as being willing to see the Member during the transition time frame for routine and/or urgent appointments.
  - Prescriptions.
    - If Member is currently using a prescription prescribed by the Provider, a dialogue of future refills (if applicable) is needed during the transition.
  - Referrals, labs, and/or imaging studies follow up.
    - If Member currently has open referrals, labs, imaging studies, etc. that were referred by the Provider, the letter must discuss the process for follow up of these services during the transition period.
  - Name, address, and phone number for new Provider (if known).
  - Language that Member's medical records will be available for ten years.

If there are any barriers during the transition process, Providers should contact Yamhill CCO's Customer Service team for assistance.

Member Transfer

At the occurrence of any one of the following events, Yamhill CCO Customer Service will reach out to the Member and/or family and offer a PCP or new PCP:

- Member newly assigned to Yamhill CCO
- Member newly re-enrolled to Yamhill CCO
- Member requests change in existing PCP
- Provider leaves town, retires or expires
- Providers choose to relinquish all Yamhill CCO assigned Members

Yamhill CCO's Chief Medical Officer has the authority to recommend reassigning any individual Member or an entire family under the following circumstances:

- One or more Member access to care issues with current PCP have been identified.
- One or more Member access to medically appropriate care issues have been identified.

Yamhill CCO will notify the PCP in writing of a reported concern of one or more of the circumstances above. Providers will have 30 days upon notification by Yamhill CCO to remedy the situation prior to Member reassignment.

Providers requesting Member disenrollment must abide by the Yamhill CCO Policy ENR-005 Enrollment and Disenrollment.

Dismissal and Disenrollment Guidelines

Definitions

Disenrollment: When a Member is removed from Yamhill CCO as the Member's designated CCO following specific guidelines established by the Oregon Health Authority.

Dismissal: When a Member is removed from a clinic or medical practice following specific guidelines established by Yamhill CCO and in accordance with established OHA guidelines.

Verbal abuse: Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

Requirements

OHA has established specific requirements for when a Member can be disenrolled from the Member's designated CCO. These requirements are outlined in detail in Yamhill CCO Policy ENR-005.

Request for disenrollment from Yamhill CCO may occur for the following reasons consistent with OAR 410-141-3810. These include:

- When a Member makes credible threats of or commits acts of violence.
- Evidence of uncooperative or disruptive behavior except where this is a result of the Member's special needs or disability.
- Commits fraudulent or illegal acts.

Should you encounter any of these situations, contact Yamhill CCO Provider Relations for assistance.

Although there are Oregon Health Authority (OHA) guidelines for disenrollment of Members, Yamhill CCO is responsible for establishing policies and procedures for dismissal of a Member from a clinic or medical practice. The philosophy of Yamhill CCO is to encourage Members and the assigned Provider to resolve complaints, problems, and concerns at the clinic level whenever possible. The Provider should document the attempts taken to resolve the issue, address barriers and assistance provided to the Member. Before discharging or dismissing a Member or requesting a Member be

disenrolled from Yamhill CCO, the PCP must request Yamhill CCO involvement to help resolve the problem or concern.

If the decision is reached to dismiss a Member, a letter must be sent to the Member informing the Member of the dismissal. The letter must include the reason for the dismissal and any actions taken to resolve the issue. The letter must also include the Member's name, date of birth, address, and client number. Secure email a copy of the discharge letter to Providerrelations@Yamhillcco.org

Upon receipt of the request, Yamhill CCO will render a decision within five (5) business days on whether the request has been approved. Provider Relations will be notified of any potential reassignment request. The Contracting Department will contact the Provider for remediation strategies. If this issue involves missed appointments, a reminder that Yamhill CCO Members cannot be billed for missed appointments.

PCPs are asked to provide urgent care for the dismissed Member for 30 days after the Member is notified of the dismissal to ensure continuity of care.

When a Member cannot be dismissed

According to OHA Administrative Rule 410-141-3800-3810, Members cannot be dismissed from a PCP or disenrolled from Yamhill CCO solely because of any of the following reasons:

- The Member has a physical or mental disability.
- The Member has an adverse change in health.
- The PCP or Yamhill CCO believes the Member's utilization of services is either excessive or lacking, or the Member's use of plan resources is excessive.
- The Member requests a hearing.
- The Member exercises the option to make decisions regarding the Member's medical care and the Provider/Yamhill CCO disagree with the Member's decisions.

Termination of Providers Panel Participation

In accordance with the Provider contract section 3.3 *Licensure*. Provider shall obtain and maintain and require its employees and agents rendering services under this Agreement to obtain and maintain, all required licenses, certificates, or qualifications, and to give Yamhill CCO immediate notice of the lapse, termination, cancellation, limitation, qualification, or suspension of the same. Provider and Group Providers shall maintain all appropriate licenses and certifications mandated by Yamhill CCO Policies and governmental regulatory agencies, including without limitation, DEA certification and licensure to practice medicine in the State of Oregon. No Provider or Group Provider shall provide Covered Services to Members under this Agreement unless and until the Provider or Group Provider has been approved by Yamhill CCO using the Credentialing Guidelines.

Billing Members

OHP/ Yamhill CCO does not collect co-payments for services provided to Members. Providers are prohibited from billing a Yamhill CCO Member for Medicaid covered services. Members may only be billed if all the following criteria are met:

- The service is not covered by Medicaid, the Oregon Health Plan.
- All reasonable covered treatments have been tried or the Member is aware of reasonable covered treatments but selects a treatment that is not covered.
- Prior to providing the treatment/service Member and Provider have completed an OHP Client Agreement to Pay for Health Services form (OHP 3165).
- The service is scheduled within 30 days from the date the Provider signed the OHP Client Agreement to Pay form.
- The Provider must ensure the Member OHP Client Agreement to Pay form states the service is not covered by the OHP and that the Member is agreeing to pay for the service.
- Members cannot be billed for missed appointments.

The OHP Client Agreement to Pay for Health Services form (OHP 3165) can be found on the OHA website.

If the Member accepts financial responsibility for a non-covered service, payment is a matter between the Provider and the Member subject to the requirements of OAR 410-120-1280.

Access and Cultural Considerations

Yamhill CCO assures the established Provider network can serve the expected enrollment in the service area. This is accomplished by evaluating the network of Providers to ensure it is sufficient in number, mix and geographic distribution to offer an appropriate range of preventative, primary care, specialty, and long-term service supports for physical, oral, and behavioral health. The network will have adequate access and if a participating Provider is not available within the network, accommodation will be made for out of network coverage.

Yamhill CCO ensures the network and services provided by the network are sufficient to deliver accessible, high quality, and culturally and linguistically appropriate services to Members. Review of Providers, network composition, capacity, utilization, and other data is done at a minimum annually and when a significant change to the network occurs. These reviews assure the appropriate range of preventive, primary care, and specialty services. If through this review a disparity is identified, Yamhill CCO actively works to address the gap through contracting and other strategies.

Language interpretation requirements

All contracted Providers must make interpretation services available to Yamhill CCO Members. Interpretation must be available during and after hours for consultation and provision of care. Interpretation can be provided by certified or qualified staff, or by a certified or qualified interpretation

service either on site, via video, or over the telephone. Interpretation should not be provided by a Member of the patient's family or ad hoc interpreter. Primary performing Providers who have passed a language proficiency exam in the Member's preferred language can offer in-language services directly.

Bilingual Staff as Interpreters

Qualified staff must be designated by the Provider office as an individual who will provide oral or sign language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the Provider's office that they are:

- Proficient in speaking and understanding both English and at least one other spoken language or sign language, including any necessary specialized vocabulary, terminology, and phraseology; and
- Able to effectively, accurately, and impartially communicate directly with individuals who use sign language or prefer a language other than English.

Language proficiency must be demonstrated with a passing score on a standardized language proficiency exam.

If the staff Member does not meet the above criteria (example: interpretation is not part of the staff Member's job duties) then the bilingual staff Member can only provide interpretation services if there is an emergency involving an imminent threat to the safety or welfare of an individual or public.

Passport To Languages

Yamhill CCO coordinates and pays for interpretation services for Members' medical appointments for covered services through the Yamhill CCO preferred vendor, Passport to Languages (PTL).

To arrange for an interpreter to be present during an appointment or for telephone interpretation the Provider can call PTL at 503-297-2707or request services via the Passport to Languages website. The Provider must submit a request at least two (2) working days prior to the appointment date.

PTL's Customer Service staff sends a fax or email to the Provider's office to confirm that interpreter arrangements are complete.

For urgent needs (fewer than 48 hours' notice), call PTL's Customer Service department at 503-297-2707 to arrange for an interpreter.

Yamhill CCO's vendor Passport to Languages does not offer the following services:

- Appointment reminders*
- Scheduling or rescheduling appointments*
- Relaying test results*
- Registration for procedures/admissions*

- Telephonic services less than 10 minutes in duration*

*These services must be provided by all Providers in a culturally competent manner including providing to those Members who prefer a language other than spoken English.

It is the responsibility of the clinic or Provider to offer appropriate communication in the language the Member prefers at all points of contact and information sharing.

Look on the Yamhill CCO website or CIM for more information about language access. The Language Access Guide provides quick information.

The Language Access Toolkit provides additional details as well as reporting language access information.

Performance Monitoring

The reappraisal process includes the following components, as available, which are reviewed as part of the recredentialing profile at least every three (3) years:

- Profiles on the utilization of resources.
- Adverse outcomes/sentinel event cases.
- Member complaints.
- Access and site visit audit results.
- Medical record documentation audit results.
- Quality Bonus/Preventive Health Measure rates.

Data is compared to the thresholds established by the Quality Improvement (QI). If the Provider exceeds any threshold, the Provider will be referred to QI for review and recommendation. Provider performance reviews that result in the recommendation of probation or other disciplinary process will be implemented per Yamhill CCO policy and tracked by QI.

Data Requests

Upon request all data received from Providers should be accurate and complete. Yamhill CCO will ensure this by:

- Verifying the accuracy and timeliness of reported data, including data from network Providers compensated through capitation payments;
- Screening the data for completeness, logic, and consistency. Yamhill CCO will make data requests from Providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.

Applicability of State and Federal Laws

As a State contractor, Yamhill CCO receives State funds to provide services to Yamhill CCO Members. Participating Provider providing services to these Members, are subject to laws applicable to individuals and entities receiving state and federal funds. Participating Providers who treat Members are required to comply with applicable state and federal laws and regulations regarding Medicaid and Medicare.

Provider Relations

Yamhill CCO Provider Customer Service can assist in the following ways:

- Provide Yamhill CCO policies and procedure information to office staff.
- Provide education to office staff to gain access to PH Tech CIM3 portal.
- Answer questions about the Participating Practitioner Agreement and clarify information contained in this manual.
- Act as a liaison for other Health Plan issues.

Contact Yamhill CCO Provider Customer Service at 855-722-8205 for information about Provider Relations or email to Providerrelations@Yamhillcco.org .

Medical Management

Clinical Practice Guidelines

Yamhill CCO, through its Quality and Clinical Advisory Panel (QCAP) reviews and adopts practice guidelines that define standards of practice as these pertain to improving health care quality for major disease/diagnoses and meet the needs of Yamhill CCO Members. These guidelines are based on best practices and support the excellent care provided to Yamhill CCO Members. These resources help identify health and lifestyle issues. The guidelines will also help Providers and Members learn and use the best treatment methods. Yamhill CCO guidelines are reviewed and updated periodically and made available through the Yamhill CCO website.

Member Primary Care Provider (PCP Assignment)

All Yamhill CCO Members have a primary care Provider (PCP) who manages the Member's medical needs. Members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice. PCPs are automatically assigned when the Member enrolls with Yamhill CCO. Auto assignment is based on where the Member lives.

Members have 90 days from the date of enrollment to choose a PCP, if one is not chosen Yamhill CCO will assign one.

PCP Assignment and Changing PCPs

Members can call Customer Service within the first 90 days of enrollment with Yamhill CCO to select a new PCP. PCPs, at the request of the Member, can help a Member select the PCP's clinic by calling Customer Service. PCP change requests go into effect at the time the request is made.

Members or the Member's representatives may change PCP:

- At any time
- If discharged from a clinic or by a Provider

Members receive an ID card from Yamhill CCO when enrolled and any time the PCP assignment changes, or there is a change of name, benefits, or household Members.

The PCP should download the Member roster timely for newly assigned Members and check eligibility regularly to ensure that Members are eligible and assigned to the PCP and clinic. If a PCP submits a claim for a Member not assigned to them without a referral, the claim will be denied. Call coverage payment will not be restricted by covering call for PCPs.

Coverage and Authorization of Services (Prior Authorization)

Prior Authorization List

The prior authorization list can be found in CIM3 as well as the Yamhill CCO website. Always look to these locations for the most current list.

No Prior Authorization Required and Member Self-Referral Services

There are services that do not require prior authorization or referral. Refer to the Member Handbook or via the Yamhill Community Care Benefit List for more information. Additional information related to covered services can be found by referencing the OHP prioritized list.

Second Opinion

A second opinion is performed by an independent clinician and may be requested by a Member or Provider. Members do not need authorization to seek a second opinion from an in-network Yamhill CCO Provider. If a Member wants a second opinion from an out-of-network Provider Yamhill CCO approval is required. Second opinions are provided at no cost to the Member. There are times when a Yamhill CCO Medical Director may request an external review. This could include when clinical indications are not clearly established, or to gather information when the indications for a procedure or treatment do not clearly meet criteria.

Prior Authorization Review

Yamhill CCO requires prior authorization for services and items that do not pair with a diagnosis or are not covered per the criteria listed on the Prioritized List of the OHP benefit plan. This requirement applies to both medical and behavioral health services. The Yamhill CCO PA List is available on the Yamhill CCO website as a starting point for guidance with CPT and HCPCS codes. The PA list will cite the date when a prior authorization requirement began and list the end date for prior authorization, if relevant.

The prior authorization process is intended to determine if a service or item is medically necessary when considering the Member's conditions in relation to Oregon Health Plan benefits and coverage. Providers can contact Yamhill CCO Customer Service if there are questions on prior authorization requirements for specific codes and services.

All denial decisions for medical necessity require an internal review by the Yamhill CCO Medical Director. Denials not based on medical necessity may be made by a Clinical Nurse Reviewer following established review criteria.

Pharmacy Formulary and Utilization Management

The Pharmacy UM Program, in collaboration with the Oregon Regional Pharmacy and Therapeutics Committee, monitors plan-wide drug utilization trends and implements procedures to improve the quality, safety, clinical efficacy and cost-effectiveness of drug therapy for Yamhill CCO Members. This program is used to evaluate inappropriate prescribing or utilization practices; monitor and profile pharmacy-Provider dispensing patterns; and develop educational materials to inform prescribing Providers of the relative efficacy and costs of various drug therapy alternatives.

Providence Pharmacy Services manages pharmacy benefits for Yamhill CCO Members. Prior authorization of services is rendered through Providence Health Plan after submission of an authorization request. Contact Pharmacy Customer Service to submit a prior authorization. The Yamhill CCO Formulary can be accessed on the Yamhill CCO website.

Authorization decisions are provided by telephone or through the pharmacy Provider portal within 24 hours of submission for prior authorization.

Yamhill CCO Pharmacy Customer Service: 503-574-7400 or 877-216-3644 from 8 a.m. – 6 p.m. Monday – Friday.

Provider Retrospective Authorizations

Yamhill CCO accepts requests for up to 90 days retro to the date of service. Request submitted beyond the 90-day timeframe, will receive contact from Yamhill CCO and the request will be withdrawn. Yamhill CCO will consider rendering a UM review depending on the circumstances that caused the request to be submitted as retro.

Provider Reconsiderations

If there is a disagreement with a claim or prior authorization decision, the Provider should work with the Member to utilize the Member's appeal rights. The Member must give permission for an appeal to be filed on the Member's behalf.

Reconsiderations are reviews on the initial decision and documentation cannot be submitted. The process to submit for reconsideration is located below. Incomplete request will be closed as incomplete.

Claim Denials

Timely Filing:

- If due to a system issue (submitted electronically and there is documentation of the submission) contact the Claims Department. No reconsideration is required.

- If due to any other issue a reconsideration form with reason completely indicated as to why timely filing was not met. Submit to Provider Appeals Provider.appeals@Yamhillcco.org or fax to 503.765.9675.

Pricing:

- Contact the Claims Department or Provider Relations Providerrelations@Yamhillcco.org
- No reconsideration is accepted for this issue.

Corrected Claim:

- Contact the Claims Department or resubmit a corrected claim.
- No reconsideration is accepted for this issue.
- Prior Authorization: No reconsideration is accepted for claims denied for no prior authorization. The retrospective review process must be used.

Prior Authorization Denials

Providers should encourage Members to utilize the Member appeal process for this type of denial. Yamhill CCO will only review the prior authorization information submitted in the original request no new clinical information will be reviewed. If there is additional clinical information, a new prior authorization request should be submitted.

Reconsideration Request Submission Time Frames:

Claim Denials- Reconsideration must be received within 60 days from the date of the claim denial. Yamhill CCO will not process a reconsideration of a claim denied for no prior authorization.

Prior Authorization Denials – Reconsideration must be received within 60 days from the date of the denial. Yamhill CCO will not accept additional information for reconsideration. This is a review of the information submitted in the original authorization request. If there is new clinical information, a new prior authorization request should be submitted.

Reconsideration Review Time Frame:

Yamhill CCO has 60 days to process a Reconsideration request. A fax with the resolution of the appeal/reconsideration will be sent. Do not resend a request if no response is received after 60 days. Send an email to: Provider.appeals@Yamhillcco.org or call the Yamhill CCO Appeals Department.

Reconsiderations received outside of the time frame will not be accepted.

Form and Required Documentation

Providers must submit the Yamhill CCO Provider Reconsideration Form for the request to be accepted.

Submit the completed form one of the following ways:

Attn: Yamhill CCO Appeal and Grievance Department

Fax: 503.765.9675

Email: Provider.appeals@Yamhillcco.org

Send the request with Secure in the subject line to protect Member confidentiality as required under HIPAA. The Yamhill CCO Appeal and Grievance Department can be reached via phone at 971.345.5933, please use the Provider prompt.

A Provider appeal or reconsideration is not the same as a Member appeal; to appeal on behalf of the Member, the Member must give written authorization to submit an appeal on the Member's behalf.

Medical Record and Personal Info Privacy and Confidentiality

Members have the right to talk with health care Providers in private, and to have all communications about the Member's care and all information in the Member's medical records kept confidential. In addition, any personal information that a Member gives when enrolled with Yamhill CCO is protected and will remain confidential. Yamhill CCO will make sure that unauthorized individuals cannot see or change anything related to Member records.

- Yamhill CCO must obtain written permission from a Member, or from the Member's legally appointed representative, before giving medical information to anyone who is not directly providing care or responsible for paying for the Member's care, except for purposes that are specifically permitted by State and Federal laws or requirements (such as for use by programs that review medical records to monitor quality of care or to combat fraud and abuse).
- Members have the right to look at, or receive a copy of, the Member's complete medical record or have the Member's medical record transferred to another Provider. The Member must be informed there may be a cost for copying the medical record.
- Members have the right to ask for changes and/or addendums to the Member's medical record. In this instance the Provider and Yamhill CCO would work together to decide if changes should be made.
- Members have the right to know how health information has been shared with others inappropriately, as required by federal and state regulations.
- Members have the right to have Yamhill CCO transfer a copy of the medical record to another Provider.

Providers shall employ reasonable administrative safeguards consistent with the security rules in 45 CFR Part 164 to ensure Member information is used or disclosed in a manner consistent with applicable State and federal laws.

Medical records are intended to document conditions, services received, and referrals made.

Notice of Privacy Practices (NPP)

The Notice of Privacy Practices explains Member rights to keep personal information private, rights about their records and how Members can get access to them. The notice tells how Yamhill CCO uses Member personal information and the laws in place that Yamhill CCO must follow. A copy of our Notice of Privacy Practices, by calling Customer Service at 855-722-8205 or download one from the Yamhill CCO website.

Notice of Adverse Benefit Determination (NOABD)

The NOABD letter is a written notice that Members receive if a claim or prior authorization is denied. The NOABD provides Members with information about why a service or item was denied and the appeal rights with a denial decision.

Waivers for Non-Covered Services

A waiver for non-covered services is not standard process, but an exception is allowed if a medical service or item is determined to be medically necessary. Prior authorization is required for consideration of an exception. The Yamhill CCO Medical Director will review the prior authorization and determine if the available clinical information supports an approval for the service or item.

Hospital Services

Inpatient and subacute facility stays require prior authorization when Yamhill CCO is the primary coverage. This requirement applies to in-state and out-of-state services. Members that have Medicare as primary do not require a prior authorization for a stay at Yamhill CCO, with the exception of transplants and bariatric surgeries, and in cases where Medicare has denied the stay. Emergency room visits and Observation stays of 24 hours or less do not require prior authorization.

Not available Locally

Yamhill CCO is required to have a network of local Providers available for Members, when possible. Members are encouraged to engage with Providers and services that are in-network and local before seeking care from Providers that are not in the region where the Member lives. Exceptions can be made for out of network Providers when the medical services are not available locally. Prior

authorization is required for all out of network services. Documentation is required to support why the services are necessary from an out of network Provider.

Urgent, Emergency and Post-Stabilization Services

Members seen in follow up to an ED visit by a PCP are required to have assignment to that PCP clinic.

Yamhill CCO does not:

- Require prior authorization for urgent and emergency services. Members may access these services 24 hours a day, 7 days a week.
- Limit what constitutes an emergency medical condition based on lists of diagnosis or symptoms.
- Hold Members liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.
- Refuse to cover emergency services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP of the Member's screening and treatment within 10 days of the presentation for emergency services.
- Deny payment for treatment obtained under either of the following circumstances:
    - A Member had an emergency medical or dental condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition or emergency dental condition.
    - A representative of Yamhill CCO instructs the Member to seek emergency services.

The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. Based on this determination, Yamhill CCO is liable for payment.

Post-stabilization services are covered and paid for in accordance with 42 CFR 422.113 as follows:

- Yamhill CCO is responsible for post-stabilization care services obtained within or outside the Yamhill CCO network that are pre-approved by a contracted partner or other Yamhill CCO representative;
- Yamhill CCO is responsible for post-stabilization care services obtained within or outside the Yamhill CCO network that are not pre-approved by a contracted partner or other Yamhill CCO representative, but are administered to maintain the Member's stabilized condition within one (1) hour of a request to Yamhill CCO or the Yamhill CCO contracted partner for prior Authorization of further post-stabilization care services;
- Yamhill CCO is responsible for post-stabilization care services obtained within or outside the Yamhill CCO network that are not pre-approved by a contracted partner or other Yamhill CCO representative, but administered to maintain, or approve, or resolve the Member's stabilized condition if:
- Yamhill CCO does not respond to a prior Authorization request within one (1) hour

- Yamhill CCO cannot be contacted; or
    - Yamhill CCO or contracted partner and treating physician cannot reach an agreement on Member's care and Yamhill CCO physician isn't available for consultation. In this situation, Yamhill CCO must give the treating physician opportunity to consult with the Yamhill CCO physician and treating physician may continue with care of Member until plan physician is reached or one of the criteria in 42 CFR 422.113 is met; and Yamhill CCO will limit charges to Members for post-stabilization care services to an amount no greater than what the organization would charge the Member if services had been obtained through the Yamhill CCO network. For cost-sharing purposes, post-stabilization care services begin upon inpatient admission.

Yamhill CCO's financial responsibility for post-stabilization services it has not approved ends when:

- A Yamhill CCO physician with privileges at the treating hospital assumes responsibility for the Member's care;
- A Yamhill CCO physician assumes responsibility for the Member's care through transfer;
- Yamhill CCO or Yamhill CCO contracted partner and treating physician reach agreement regarding the Member's care; or
- Member is discharged.

Additional information on urgent, emergency, and post-stabilization services is located in the Yamhill CCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure (MM-002).

Crisis Management

Yamhill CCO and/or partners have monitoring systems that provide for mental health emergencies, including post-stabilization care services and urgent services for all Members on a 24-hour 7 day-a-week basis. These systems are intended to address situations when a Member's stability or functioning is acutely disrupted and there is an immediate need to resolve the situation to prevent serious deterioration, higher level of care, or other adverse outcomes.

- Yamhill CCO ensures that an emergency response system is provided for Members who need immediate, initial, or limited duration response for potential behavioral health emergency situations or emergency situations that may include behavioral health conditions, including:
    - Screening to determine the nature of the situation and the Member's immediate need for Covered Services;
    - Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
    - Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
    - Provision of Covered Services and Outreach needed to address the urgent or crisis situation;
    - Linkage with the public sector crisis services, such as Mobile Crisis Services and diversion services.

- The crisis management system must include the necessary array of services to respond to behavioral health crises, which may include crisis hotline, 24-hour mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.
- Yamhill CCO will ensure access to mobile crisis services for all Members in accordance with OAR 309-019-0105, and 309-019-0300 through 309-019-0320 included below to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care facility.

Additional information on urgent, emergency, and post-stabilization services is located in the Yamhill CCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure.

Communication Among Providers/Care Coordination

In the interest of providing quality and efficient Member care, Providers should communicate the results of any treatment, including the annual gynecological exam to the Member's PCP. This allows the PCP to maintain complete Member records and fulfill the responsibilities of care coordination and consultation. Each Member has a PCP or primary care team that is responsible for coordination of care and transitions.

- Yamhill CCO coordinates physical health, oral health, behavioral health, intellectual and developmental disability, and ancillary services, between settings of care including appropriate discharge planning for short and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities. Behavioral health Providers will explain to Members the importance of collaborating behavioral health services with the Member's PCP, dentists, or previous behavioral Providers.

Care Coordination and Care Management

Care Coordination and Care Management offer a systematic process of assessment, coordination, and intervention in response to a Member's care coordination or case management needs. These services are available upon request and assigned based on the Member's specific needs.

Although all populations are at times at risk for suffering from debilitating illness or injury, the Yamhill CCO population is particularly vulnerable. A Health Risk Assessment (HRA) and a Social Determinants of Health and Equity (SDoH-E) Assessment are critical resources in determining Member needs. Care Management staff consists of Registered Nurses (RN), Medical and/or Licensed Social Workers (MSW/LCSW), Community Health Workers through the Community Health Hub, Clinical Support Specialists (CSS), and Behavioral Health Case Managers. Care Management and Care Coordination services are available to support Providers in the endeavor to identify high-risk Members and quickly address health care and social needs. Care Management can provide a plan of care for Members with chronic, medically fragile, or high utilization. Additionally, Care Management can assist Members in addressing social needs, crisis management and access to specialized clinical resources, as well as community resources.

Managing a Member's complicated or challenging health care needs requires teamwork to cost-effectively deliver high quality care. The content of the treatment plan is the responsibility of the attending Provider in collaboration with consulting Providers. Clinically specialized nurses, with oversight from physician advisors, will work closely with the PCP to facilitate coordinated care management.

Care Management services may be initiated through direct referral by calling Care Management at 503-574-6428 or via email at caremanagement@providence.org.

Traditional Health Workers

At Yamhill Community Care, efforts are made to make the community a great place to live. Traditional Health Worker (THW) is an umbrella term for frontline public health workers who work in the community, clinic and/or hospital. THWs support individuals in a variety of ways to achieve better health. THWs walk alongside Members connecting them with resources to address unmet needs.

THWs Available to Yamhill CCO Members

There are six types of THWs available for Yamhill CCO Members:

- **Community Health Worker (CHW):** An individual who meets qualification criteria adopted by the authority under ORS 414.665 and who: (a) Has expertise or experience in public health; (b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system; (c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves; (d) Assists Members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness; (e) Provides health education and information that is culturally appropriate to the individuals being served; (f) Assists community residents in receiving the care they need; (g) May give peer counseling and guidance on health behaviors; and (h) May provide direct services such as first aid or blood pressure screening.

- **Peer Support Specialist (PSS):** An individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family Member of an individual with a mental health condition to family Member of an individual with a mental health condition). A peer support specialist shall be: (a) A self-identified individual currently or formerly receiving addictions or mental health services; (b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs; (c) A self-identified individual in recovery from problem gambling. There are four categories of Peer Support Specialists:
    - Family Support: an individual who meets qualification criteria adopted under ORS 414.665 and may be either a peer support specialist or a peer wellness specialist who,

based on similar life experiences, provides support services to and has experience parenting a child who:(a) Is a current or former consumer of mental health or addiction treatment; or (b) Is facing or has faced difficulties in accessing education, health, and wellness services due to mental health or behavioral health barriers.
    - Youth Support: means an individual who meets qualification criteria adopted under ORS 414.665 and may be either a peer support specialist or a peer wellness specialist and who, based on a similar life experience, provides supportive services to an individual who: (a) Is not older than 30 years old, and (b) Is a current or former consumer of mental health or addiction treatment; or (c) Is facing or has faced difficulties in accessing education, health, and wellness services due to mental health or behavioral health barriers.
    - Adult Addictions: A person in addiction recovery who provides support services to people seeking recovery from addiction.
    - Adult Mental Health: A person with lived experience of mental health who provides support services to other people with similar experiences.

- **Peer Wellness Specialist (PWS):** An individual who meets qualification criteria adopted by the authority under ORS 414.665 and who, through community outreach, is responsible for (a) assessing mental health and substance use disorder service and support needs of a Member of a coordinated care organization, (b) assisting Members with access to available services and resources, (c) addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services, (d)and assisting Members in creating and maintaining recovery, health and wellness.

- **Personal Health Navigator (PHN):** An individual who meets qualification criteria adopted by the authority under ORS 414.665 and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

- **Birth Doulas**: A birth companion who provides personal, nonmedical support to women and families throughout a woman's (or person's) pregnancy, childbirth, and postpartum experience.

- **Tribal Traditional Health Worker:** Tribal THWs assist tribal or urban Indian communities to improve overall health care needs by providing education, counseling, and support which may be specific to tribal practices.

Yamhill CCO Community Health Hub

The Yamhill CCO Community Health Hub helps connect Members to needed programs and services that help support positive health outcomes and assist in navigating complex health systems. The primary functions of the Community Health Hub are to have a community presence, to assess

Members for social needs, to assist Members with navigation and community resource connection, to facilitate community partner engagement, and to ensure community outreach and health promotion. More information about the Community Health Hub and how to access these services can be found on the Yamhill CCO Website.

Some of the resources or services the Community Health Hub can help the Member access include:

- Community Health Workers: CHWs are field-based staff and meet CCO Members wherever they are at, working with them to navigate care and access resources to successfully manage the Member's health and well-being.
- Wellness to Learn: Connects elementary-aged children in the McMinnville School District and the families to services in the community.
- CHW Hospital Rounds: Twice a week CHWs provide hospital rounds at Willamette Valley Medical Center with the intent to assist in the transition of complex cases to home at the time of discharge from the hospital.

Multi-Disciplinary Team (MDT)

For Members with special or complex health needs, a Multi-Disciplinary Team brings together the Member's health team to identify issues and needs. The MDT may include:

- Care Coordinators and Care Managers
- PCPs or Specialists
- Caregivers
- Behavioral Health Providers
- Oral Health Providers
- County or Agency representatives.

Members of the MDT work together to understand a Member's health needs and help to ensure the Member is receiving the right treatments and services. The MDT team meets twice a month for comprehensive case review and care planning. If you want to refer a Member for a Multi-Disciplinary Team review contact Customer Service at 855-722-8205 (TTY 711).

Telehealth

Telehealth (TH) is the use of a cell phone, computer, or tablet to perform a health care visit. Telehealth is also known as telemedicine. Yamhill CCO works with contracted Providers to ensure access and the ability to use approved methods of telehealth services. Yamhill CCO covers meaningful medically proper TH visits for physical, behavioral, and dental health. Not all visits can be conducted via telehealth.

Providers may use the camera and an application to talk and see Members receiving telehealth services. Some Yamhill CCO Providers use Facetime, Skype, Zoom, Microsoft Teams, and applications through the electronic health record system like EPIC.

When using programs like Facetime and Skype a Provider may ask the Member to be alone in the room and will ask if they agree to have the visit online. Some online applications are not as secure as others. Business versions of Skype, Zoom and Microsoft Teams are HIPAA compliant.

Telehealth And Language Services

Just like with in-person visits, language services are available. Members who are deaf or hard of hearing can also obtain help for a telehealth (TH) visit. If you have questions about using these services for a TH visit call customer service. All visits should meet the Member's cultural needs. If a Member does not have what is required for a TH visit, the Member should contact Customer Service at 855-722-8205 (TTY 711) for help.

Providers cannot use only TH; Providers need to offer in-person visits as well. Yamhill CCO continues to work with in-network Providers to ensure access to the types of approved TH that work best for Yamhill CCO Members.

Quality Assurance Program

Yamhill CCO's Quality Assurance Program provides a mechanism for systematic, coordinated, and continuous monitoring. The goal is to improve Member health and the quality of services provided by Yamhill CCO.

All participating Providers will cooperate with the requests and requirements of quality review organizations when such activities pertain to the provision of services for Yamhill CCO Members.

All participating Providers are required to comply with Yamhill CCO practice guidelines, medical policies, QI program, and Medical Management program, as developed by Yamhill CCO Board of Directors, Yamhill CCO Clinical Advisory Panel (CAP) and Yamhill CCO Community Advisory Council (CAC). Providers are required to participate in the State's external quality review of Yamhill CCO, if requested.

Claims

Eligibility Verification

Each Yamhill CCO Member receives a Member Identification Card. Information on the card will help explain the patient's eligibility, indicates the Primary Care Provider or Clinic, with the appropriate telephone numbers for Yamhill CCO Customer Service, Preauthorization and Pharmacy information. The cards also explain to Members how to reach our:

- Oral Health Care Organization, Capitol Dental Care,
- Behavioral Health Team, Yamhill County Health and Human Services, and
- Non-emergent medical transportation agency, WellRide.

Please reMember that a Member Identification Card is not a guarantee of eligibility. Yamhill CCO has no mechanism for retrieving the Member Identification Card when the Member is no longer eligible. CIM can be utilized to verify past eligibility. Please utilize Customer Service, MMIS or the CIM Portal to verify current eligibility.

It is the responsibility of the Provider to verify a Member is eligible on the date of service. The Provider assumes full financial risk of serving a Member not confirmed as eligible for the service provided on the date of service.

To request CIM access or to verify eligibility contact Customer Service at 855-722-8205.

CIM-The Yamhill CCO Provider Portal

CIM is the portal used by the Yamhill CCO network. If you do not have access to CIM contact Provider Customer Service at 855-722-8205. Use CIM to:

- Verify Member benefits
- View patient roster

- Submit referrals and prior authorizations

- View existing referrals
- Get claims information
- Get explanation of payment (EOP)
- See PCP Quality Reports
- Read newsletters
- Stay updated

Filing Claims

Yamhill CCO will be billed for all services provided to Health Plan Members regardless of primary or secondary diagnosis position. All bills for service to Yamhill CCO Members should be submitted directly to Yamhill CCO. Members only receive a bill for non-covered services when there is an authorization denial from the health plan and a waiver form has been signed between a Member and the Provider. The waiver form "Client Agreement to Pay for Health Services" (Form OHP 3165) is available on the OHP website.

Claims for Yamhill CCO Members should be submitted electronically whenever possible. Paper claims can be mailed to:

Yamhill Community Care Claims
PO Box 5490
Salem OR 97304

Yamhill CCO accepts electronic claims through various clearinghouses. For more information, contact Provider Relations Representative or Yamhill CCO Customer Service.

Information Required for Filing Claims

To ensure timely claims processing, all claims must be submitted on a CMS 1500 form (formerly a HCFA 1500 form); or, for facilities, on a UB-92 form.

Information on the claim form must be printed in black ink with a standard 10- or 12-point type face. All information must be legible.

Place required information only in the appropriate field and be sure to align the form so that each item is properly located within the box.

The list below includes general categories of information necessary for claims processing. If any of this information is missing from the claim, it could be delayed or returned.

- Member’s full name and date of birth.
- Yamhill CCO Member number (including the identifying suffix).
- Information about other insurance coverage.
- ICD-10 CM codes (code to the highest level of specificity).
- Description of any accident circumstances.
- CPT or HCPCS codes for services performed (use current year codes).
- Place service codes per CMS guidelines (use list effective 8/01 available on the CMS website).
- Itemized charges, by date of service (only one service per line).
- Provider’s name, UPIN #, TIN# and vendor address (Box 33)
- Name and address of facility where services where rendered (Box 32 on HCFA)

Overpayment

Yamhill CCO is committed to ensuring the appropriate adjudication of claims. However, when overpayments of claims occur, Yamhill CCO will recover the overpayment in the most efficient and cost-effective way for Yamhill CCO and the Provider. Yamhill CCO has a mechanism in-place for network Providers to report receipt of an overpayment.

The Provider is required to notify Yamhill CCO and return the full amount of the overpayment within 60 calendar days after the date on which the overpayment was identified and provide in writing the reason for the overpayment. In the event Yamhill CCO makes an overpayment to a Provider, Yamhill CCO will recover the full amount of the overpayment from the Provider.

Timely Filing Guidelines

Claims must be submitted on a timely basis. OHA requires that Providers submit all claims within 120 days (4 months) of the date of service. The Member cannot be billed for these services if the Provider does not file timely.

Yamhill CCO may choose to waive the timely filing rule for Medicaid if a claim meets one of the following criteria and proof is submitted:

- Newborns
- Medicare coverage
- Other insurance coverage
- Maternity-related expenses
- Claims denied by Workers' Compensation
- Claims processed or adjusted after retroactive eligibility changes

If a Provider disagrees with the way a claim was paid, Yamhill CCO must be notified within 180 days of payment or denial of the claim.

Place of Service Codes

Place of service codes and descriptions can be referenced Online.

Coordination of Benefits

Situations may arise in which charges for a Member's health services are the responsibility of a source other than Yamhill CCO. The following is a list of situations that a Yamhill CCO Member may encounter:

- Workers' Compensation

- Liability Auto Insurance
- Third Party Payer Coordination of Benefits ensures that the appropriate insurers are held responsible for the cost of a Member's health care and is one of the factors that can help hold down premiums and overall health care costs.

Always ask Members if they have additional insurance coverage or when being seen for an injury if this injury is related to a work or auto accident.

Denied PCP Claims

Claims for PCPs who see a Member not assigned to the Provider or the clinic without a referral who receive a denial may follow these steps to help resolve the denial:

- Providers should contact customer service at 1-855-722-8205. Customer service will clarify the reason for denial and confirm the Member's PCP with contact information.
- The Provider will then need to work with the Member's PCP for the PCP to submit the referral.
- If the Provider has access to CIM, the Provider can send an inquiry on the claim to ask for a reprocess.

Submitting a Retro Referral

To submit a retro referral, the Provider will need to submit the referral with a back date. Please call customer service at 1-855-722-8205 for additional support. Submit retro referrals through the CIM portal.

For questions about a claim denial, a referral or to make a PCP change at the request of the Member contact Customer Service.

Benefits and Services

Oregon Health Plan Benefits

Yamhill Community Care Organization (Yamhill CCO) has contracted to provide benefits to eligible Oregon Health Plan (OHP) Members. The medical, dental, or behavioral health services OHP covers for each Member is called a “benefit package.” Yamhill CCO defines a benefit package using a priority process emphasizing primary care, preventive care, managed care, reduced cost-shifting, and monitoring the purchase and use of expensive medical technology. Each Member receives a benefit package based on certain things, such as age or healthcare condition. Members of a household may receive different benefit packages. Benefits covered under OHP and plan specific guidelines are located on the Yamhill CCO website.

If you have any questions regarding the Yamhill CCO Benefit Package (covered vs not covered services), please contact the Yamhill CCO Customer Service at 855-722-8205.

Yamhill CCO Plan Benefits

Prioritized List of Health Services

The OHP covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits. To determine if a service is covered by Yamhill CCO, check the prioritized list on OHA’s website.

The line on the prioritized list determines whether or not a treatment is covered by the OHP.

- Diagnosis and treatment pairs that fall above the line are generally covered by the OHP and Yamhill CCO.
- Diagnosis and treatment pairs that rank below the line are not generally covered benefits of either the OHP or Yamhill CCO.

The list can also be accessed by calling DMAP Provider Services at 1-800-336- 6016.

If a service is not covered by the OHP and a Provider decides that treatment is essential, an authorization request may be submitted with relevant documentation to the Utilization Management department. On this type of request ensure the request for an exception is documented as well as noting “Exception” on the request coversheet.

Covered services for OHP Members may include, but are not limited to:

- Provider/physician services
- Outpatient hospital

- Inpatient hospital
- Prescription drugs
- Hospice
- ER transportation/ambulance
- Hearing aids, batteries, services
- Durable Medical Equipment and Supplies
- Home Health/private duty nursing
- Physical therapy/occupational therapy
- Speech/language pathology
- Vision exams, therapy, and materials
- Chemical dependency services
- Family planning services
- Non-Emergency Medical Transportation (NEMT)
- Mental Health Services
- Dental Services
- Care Coordination and Intensive Case Management Services

Some of these services are administered directly by Yamhill CCO, Providence Plan Partners, or Capitol Dental Care for oral health.

Contact information is located on the Yamhill CCO Member ID card.

Current condition/treatment pairs on the Prioritized List of Health Services can be found on OHA's website.

The PCP has responsibility for the management of the Member's health care needs. OHA describes non-covered conditions/treatments to Oregon Health Plan Members as "services that get better without treatment, diseases or conditions for which there is no useful treatment, or treatment that is just cosmetic."

Diagnostic services, which are necessary and reasonable to diagnose the presenting condition, are covered regardless of the placement of the condition on the list.

Also covered are one-time referrals for diagnostic clarifications and treatment planning.

Please note that the Member will likely not be able to see that Provider again (unless diagnostic clarification makes it appropriate to do so), so treatment planning recommendations made during that visit should be considered for implementation by the referring PCP.

Yamhill CCO may, on a case-by-case basis, elect to approve coverage for therapeutic services for those conditions that fall below the line.

The following criteria must be met for the Plan to consider the request:

- The condition severely incapacitates the individual, preventing or interfering with function and proposed therapy will significantly improve the condition.

- Lack of therapeutic treatment will result in deterioration of the condition, which will then require more costly and involved medical care.
- Member has a co-occurring diagnosis that is paired with the requested treatment on the prioritized list.

The request for coverage (a benefit exception) must be made in writing and must include documentation of the above as well as all pertinent medical information. The request should be directed to the Utilization Management Department. As medical information will be required, a telephone request will not be adequate to initiate the review. Covered services are provided in no less than the amount, duration, and scope of the same services to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 34 440.230 and for Members under the age of 21, as set forth in 42 CFR 441 subpart B.

Yamhill CCO ensures:

- Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
- Not to arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. Excluded Services and Limitations Certain services or items are not covered under any program or for any group of eligible Members. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in 410-141-3830 and the individual program chapter 410 OARs. Information on these services is also located in OAR 410-120-1200.

Yamhill CCO places or may place appropriate limits on a service:

- On the basis of medical necessity criteria.
- For utilization control, provided that:
    - Services furnished can reasonably achieve their purpose.
    - Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Member's ongoing need for such services and supports.
    - Family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used consistent with contractual requirements.

Coordination of Benefits

Situations may arise in which charges for a Member's health services are the responsibility of a source other than the Plan. The following is a list of situations that a Yamhill CCO Member may encounter:

- Workers' Compensation

- Liability Auto Insurance
- Third Party Payer Coordination of Benefits ensures that the appropriate insurers are held responsible for the cost of a Member's health care and is one of the factors that can help hold down premiums and overall health care costs.

Always ask Members if they have additional insurance coverage or when being seen for an injury if this injury is related to a work or auto accident.

Yamhill CCO Summary of Benefits

Services covered by Yamhill CCO

To determine if a service is covered use the following:

- Yamhill CCO Benefit list
- OHP Benefit List
- Prioritized List
- Yamhill CCO Prior Authorization List

Services covered by OHP

Some services are covered by OHP Fee-for- Service but are not covered by Yamhill CCO.

For more information on these services call OHP Customer Service at 800-699-9075.

- There are two types of benefits OHP covers directly: Services where Members get care coordination from Yamhill CCO.
- Services where Members get care coordination from OHP.

Services with Yamhill CCO care coordination

Yamhill CCO provides care coordination for some services. Care coordination includes rides from WellRide for covered services, support activities and any resources you need for non-covered services.

Contact Yamhill CCO for the following services:

- Planned Community Birth (PCB) services include prenatal and postpartum care for people experiencing low risk pregnancy as determined by the OHA Health Systems Division. OHA is responsible for providing and paying for primary PCB services including at a minimum, for those Members approved for PCBs, newborn initial assessment, newborn bloodspot screening test, including the screening kit, labor and delivery care, prenatal visits and postpartum care.
- Long term services and supports (LTSS) not paid by Yamhill CCO.
- Family Connects Oregon services, which provides support for families with newborns.

- Helping Members to get access to behavioral health services. Examples of these services are:
    - Certain medications for some behavioral health conditions
    - Therapeutic group home payment for Members under 21 years old
    - Long term psychiatric (behavioral health) care for Members 18 years old and older
    - Personal care in adult foster homes for Members 18 years and older

For more information or for a complete list of these services, call Care Management at 833-257-2191 or Customer Service at 855-722-8205.

Services that OHP pays for and provides care coordination

Contact OHP for the following services:

- Comfort care (hospice) services for Members who live in skilled nursing facilities
- School-based services that are provided under the Individuals with Disabilities Education Act (IDEA). For children who get medical services at school, such as speech therapy.
- Medical exam to find out if Members qualify for a support program or casework planning
- Services provided to Healthier Oregon Program Members
- Abortions and other procedures to end pregnancy
- Doctor aided suicide under the Oregon Death with Dignity Act and other services

Contact OHP's Acentra Care Coordination team at 800-562-4620 for more information and help with these services.

Members may qualify for a free ride from WellRide for any of these services.

Preventive Covered Services

Refer to the Yamhill CCO and OHP benefit information for more information on covered services.

- Yamhill CCO Benefit list
- OHP Benefit List

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT services offer "well-child" medical exams, screening and diagnostic services to determine any physical or mental defects in Members under age 21. EPSTD services also covers health care, treatment, and other measures to correct or help any defects and chronic conditions discovered.

If a Member needs EPSDT, PCPs help them get the care needed. Primary care dentists help Members with any dental EPSDT services.

All EPSDT services are provided at no cost to Members up to the age of 21. If the EPSDT Member or family need help with setting up visits for services complete the Community Health Hub referral.

Non-emergent medical transport (NEMT) is available to and from covered EPSDT Provider visits. Providers and Members can call WellRide at 844-256-5720 to set up a ride or for more information on NEMT. Call Capitol Dental to set up or for more information on oral health services at 800-525-6800.

PCPs that provide EPSDT services to a Member must enter into a written agreement with the Member or Member's representative that states that the PCP will be the Member's regular source for EPSDT services for a set amount of time. The PCP will maintain the Member's combined health history that includes information received from all other Providers.

The minimum periodic EPSDT screenings must have but are not limited to:

- A full health and development history that assesses both physical and mental health development;
- Nutritional status is assessed;
- A full unclothed physical exam that will include an inspection of teeth and gums;
- Immunizations that meet medical care standards;
- A blood lead screening test and other testing that may be needed based on age and risk;
- Health education;
- Hearing and vision testing; and
- Periodic scheduled screenings at each state of life that starts with the neonatal exam up to age 21. View recommendations.
- EPSDT fact sheet
- A test or screening may show the need for:
    - Vision or hearing problems and the need for glasses or hearing aids;
    - Oral Health problems like help with pain, fixing a tooth, or taking care of dental health; and
    - Immunizations that are needed based on medical care standards

These services will be given to eligible EPSDT Members if a test or screening shows the service is medically needed. If during any exam or test a medical, dental, mental health, or substance abuse condition is found the Provider will explain what is needed and will do all referrals. The Member does not have to go to more services but if they agree to and need help, the PCP will help them, or they will refer the Member to the Care Coordination/Care Management Program for help with setting up more visits with the other Providers.

EPSDT services in child health care include timely start of treatment, if needed, generally in the outer limit of six (6) months after requested.

Services Not Covered by EPSDT

Some services are not covered by EPSDT, these include but not limited to the Supplemental Nutrition Assistance Program (SNAP) or other social services programs.

For assistance with these services, call 855-722-8205 (TTY) and ask for the Yamhill CCO Community Health Hub or:

- Find this information on our website on the Member Benefits and Rights page.
- More facts about EPSDT can be found Online.
- The Periodicity Table notes what health care is recommended up to age 21.

Vaccinations

These guidelines aim to increase community-wide childhood and adolescent vaccination rates in Yamhill County.

- Centers for Disease Control website.
- Oregon Health Authority Vaccines and Immunizations
- Oregon Health Authority Alert Immunization Information System

Yamhill CCO covers immunizations that meet these established medical standards:

- Child Immunization Schedule (birth to 18 years)
- Adult Immunization Schedule (19+)

Health Related Services (HRS)

HRS are services in addition to covered health care services under the OHP intended to improve health quality, care delivery and overall Member and community health and well-being. HRS include flexible services and community benefit initiatives.

The Yamhill CCO HRS program aids in the best use of funds to address Member's social risks factors, like where Member's live, to improve community well-being.

Examples of HRS flexible services are:

- Short-term housing support (if not covered by the HRSN benefit and if criteria is met)
- A scale to help monitor their weight

Examples of community benefit initiatives are:

- Classes for parent education and family support
- Home visiting services

Members or Providers can request HRS Flex funding, utilizing the form located on the Yamhill CCO website or they can call Customer Service and have a request form sent to them. After submitting a request, approval or denial notice will be sent directly to the submitter.

Members will receive a letter if the request is not approved.

There are no hearing or appeal rights for HRS non-approvals, however Members may file a complaint if they disagree with the decision by contacting Customer Service.

Yamhill CCO does not share Member specific HRS information outside of the HRS process. When a request is received it is shared only with those noted in the request, this could be Members, Providers, caregivers, or the entity related to their request.

Tobacco Cessation

Yamhill CCO pays for medications and telephone counseling with a trained coach to help Members stop using tobacco products. If a Member uses tobacco products, provide Quit for Life, toll-free at 866-784-8454 (866- QUIT-4-LIFE) information.

Prescription Drug Monitoring Program

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare Providers and pharmacists provide patients with better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies. OHA PDMP Website Page.

Dental Services

Yamhill CCO works with Capitol Dental Care for Member's dental coverage. Dental services covered by Yamhill CCO can be found on the benefit list.

- Yamhill CCO Benefit list
- OHP Benefit List

For more information related to dental benefits contact Capitol Dental Care at 800-525-6800.

Member Rights and Responsibilities

Yamhill CCO and all in-network Providers, contractors, and sub-contractors comply with any applicable federal and state laws that pertain to Member rights. All are committed to observing and protecting those rights. All Yamhill CCO OHP Members have the following rights and responsibilities:

Member Rights

Members have the right to:

- Be treated with respect and with due consideration for their dignity, and privacy. Be treated in the same manner as non-Members or other patients who receive services equivalent to covered services.
- Be treated by Providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the Member's care team, including Providers and community resources appropriate to the Member's needs.
- Freedom to choose a CCO as permitted by OAR 410-141-3700, a PCP, or service site and to change those choices as permitted by OAR 410-141-3590.
- Direct access to a
- Have a consistent and stable relationship with a care team that is responsible for comprehensive care management.

- Not be subjected to seclusion or restraint used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Materials explained in a way and in a language they can understand.
- Materials, like the Member handbook, that tell inform about CCOs, the coordinated care approach being used in the community and how to use the coordinated health care system.
- Written materials that inform about their rights, responsibilities, benefits, how to get services, and what to do in an emergency.
- Information about condition, treatments and alternatives, what services are covered, and what is not to allow an informed decision about proposed treatments. This information should be in a format that works best for them.
- A health record that keeps track of conditions, the services they've gotten, and referrals. Members can:
    - Have access to their health records unless restricted by statute.
    - Share their health records with a Provider.
- Written notices mailed to them of a denial, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations.
- Written notice about Providers who are no longer in-network.
- Be told in a timely manner if an appointment is cancelled.
- Receive integrated person-centered care and services designed to provide choice, independence, and dignity and that meet generally standards of practice and are medically appropriate.
- Services that are culturally and linguistically appropriate and support in locations as geographically close to where the Member lives or seeks services as possible and choice of Providers within the delivery system network that are if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.
- Receive oversight, care coordination and transition and planning management from Yamhill CCO within the targeted population to ensure culturally and linguistically appropriate.

- Community-based care is provided in a way that serves the Member in as natural and integrated an environment as possible and that minimized the use of institutional care.

- Services that are necessary and reasonable to diagnose the Members' presenting condition.

- Help to navigate the health care system and in accessing community and social support services and statewide resources, including cultural and language supports such as Certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the Member's care team to provide cultural and linguistic assistance appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services.

- Help from CCO staff who are fully trained in CCO policies and procedures.
- Covered preventive services.
- Access to urgent and emergent services 24 hours a day, 7 days a week without prior approval or permission.
- Receive referrals to specialty Providers for covered coordinated services that are needed based on the Member's health when required. Yamhill CCO does not require referrals to seek services from an in network specialist.
- Extra support from an OHP Ombudsperson.
- Choice of their Providers and change those choices.
- Second opinions.
- Have a friend, family Member, Member representative, or advocate accompany them to or be present during appointments and other times needed within clinical guidelines.

- Be actively involved in making their treatment plan.
- Consent to treatment or refuse services and be told the consequences of that decision, except for court-ordered services.
- Refer oneself directly to behavioral health or family planning services without getting a referral or permission from a PCP or other participating Provider.
- Make a statement of wishes for treatment. Including the right to accept or refuse medical, surgical, or behavioral health treatment and the right execute directives and powers of attorney for health care, listed in ORS 127.
- Make a complaint or ask for an appeal and receive a response.
    - Ask for a hearing if they don't agree with the appeal decision.
- Get free certified or qualified health care interpreters for all non-English languages and sign language.
- Receive communications of individually identifiable health information from Yamhill CCO by alternative means or at alternative location per 45 CFR 164.22 if the Member provides a written statement that includes:
    - A valid alternative address or other method of contact suitable for enabling the Member to receive communications from Yamhill CCO (e.g., valid cell phone number, verifiable email address); and
    - If required a clearly stated disclosure that all or part of the protected health information could put the Member in danger.

Member Responsibilities

Members agree to:

- Treat Yamhill CCO staff, Providers, and others with respect.
- Give accurate information for inclusion in the clinical record and to assist Providers to give the best care.

- Choose or help choose their primary care Provider or clinic.

- Get yearly checkups, wellness visits, and preventive care from the PCP or clinic.
- Be on time for appointments. If late, call ahead or cancel the appointment if they can't make it.
- Bring their medical ID cards to appointments. Tell the office that they have OHP and any other health insurance. Tell the Provider if they were hurt in an accident.
- Help their Provider make their treatment plan. Follow the prescribed agreed upon treatment plan and actively take part in their care.
- Follow directions from Providers or ask for another option.
- Ask questions about conditions, treatments, and other issues related to care that is not understood.
- Use information from Providers and care teams to help make informed decisions about treatment before it is given.
- Use primary care Provider or clinic for diagnostic and other care, unless it's an emergency.
- Use in-network specialists or work with their Provider for approval if they want or need to see someone who doesn't work with Yamhill CCO.
- Use urgent or emergency services appropriately. Tell their primary care Provider within 72 hours if they use these services.
- Help Providers get the health record from other Providers that may include signing an authorization for release of information.
- Tell Yamhill CCO if they have any issues, complaints, or need help.

- Assist Yamhill CCO in pursuing any third-party resources available and reimburse Yamhill CCO the amount of benefits it paid for an injury from any recovery received from the injury.

- Notify the OHP or Authority worker if pregnant and notify of the birth or the child.
- Notify the OHP if any family Members move in or out of the household.
- Notify the OHP or Authority worker if there is any other insurance available.

Member Materials

- Members receive or have access to the following materials in their preferred format from Yamhill Community Care Organization:
- Yamhill CCO Member Handbook
- Yamhill CCO NEMT Rider Guide
- Yamhill CCO OHP ID Cards at the time of enrollment and when there is a change in coverage or PCP.
- Annual Member letter (for current Members) – providing updates for the coming year with links to important information on the Yamhill CCO website.
    - New Member letter & handbook provided at the time of enrollment.

If Members have questions regarding materials sent to them by Yamhill CCO, they should be referred back to Yamhill CCO Customer Service.

Access to Care Standards

Yamhill CCO assures the established Provider network can serve the expected enrollment in the service area. This is accomplished by evaluating the network of Providers to ensure it is sufficient in number, mix and geographic distribution to offer an appropriate range of preventative, primary care, specialty, and long-term service supports for physical, oral, and behavioral health. The network will have adequate access and if a participating Provider is not available within the network, accommodations will be made for out of network coverage.

Yamhill CCO ensures the network and services provided by the network are sufficient to deliver accessible, high quality, culturally and linguistically appropriate services to Members. Review of Providers, network composition, capacity, utilization, and other data is done at minimum annually and when a significant change to the network occurs. These reviews assure the appropriate range of preventive, primary care, and specialty services. If through this review, a disparity is identified, Yamhill CCO activity works to address the gap through contracting and other strategies.

Transportation for OHP Members

Non-Emergent Medical Transportation (NEMT) NEMT program provides free-non-urgent rides, mileage reimbursement, and bus tickets (and in some cases bus passes) to covered appointments for Yamhill CCO Members who have no other transportation options. Members can schedule rides:

- 90 days in advance
- For more than one service or those that reoccur up to 90 days in advance
- Same-day visits Covered NEMT services are provided 24 hours a day, 365 days a year.

WellRide has after-hours Customer Service, call our toll-free telephone number if you need help after hours. There is a message in English and Spanish, explaining how to access alternative arrangements after hours. If you leave a message after hours and the message is clear and includes a valid phone number, we will respond to the next workday. WellRide will make attempts to contact you until they do or, if not able to reach you, a message will be left. Call Center staff document all efforts to return their call or respond to a message.

> Yamhill CCO WellRide Contact & Availability Information
>
> Toll-free: 844-256-5720 TTY/Oregon Relay Service: 711
>
> Hours of operation: 7:30 a.m.-6 p.m., Monday-Friday
>
> WellRide's call center is closed on New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.

More information on NEMT services can be found in the Yamhill CCO NEMT Rider Guide available on the Yamhill CCO website.

Emergency Transportation

Emergency ground or air ambulance transportation, when medically necessary, is a Member benefit. Transportation required to return a Member to the service area to obtain continuing care after a medical emergency also is covered. The PCP should discuss appropriate use of ambulance transportation with the Member during the initial visit in the context of Member responsibility for proper use of emergency services. 19 Return transportation is considered Non-Emergency Medical Transportation, discussed above.

Patient Advocacy

Provider may, without any constraint from Yamhill CCO, advocate on behalf of and advising a Member who is their patient, for the following:

- The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the Member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The Member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

- Such contract provisions would not be allowed unless Yamhill CCO has cited a moral or religious objection to counseling for a particular service or services and has provided written information to the State Medicaid agency.

Member Grievance, Appeals, and Hearings

Grievance and appeal system overview

Assurances through the Grievance System Members and/or Providers are assured the following through the grievance system:

- Grievances, complaints, appeals, and contested case hearings are kept confidential and have a timely and appropriate resolution.
- Yamhill CCO Members have access to a robust process for handling grievances, complaints, appeals, and contested case hearings regarding the services they receive from Yamhill CCO.
- Yamhill CCO ensures Member grievances and appeals are processed in accordance with Oregon Administrative Rules (OAR) 410-141-3875 through 410-141-3915.
- Yamhill CCO Members are informed that they have a right to file a grievance, appeal or contested case hearing orally or in writing and may have a Member representative of their choice.
- A Member, Member's representative, a representative of a deceased Member's estate, or a Member's Provider acting on behalf of and with written consent of the Member may file a grievance or appeal and request a contested case hearing.
- No punitive action will be taken against any Provider who files a grievance, appeal, request a contested case hearing or request expedited resolution of an appeal on behalf of a Member.
- Yamhill CCO will include in each notice of resolution with the determination not found in favor of the Member that they may present the grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.
- That Yamhill CCO, its delegates, subcontractors, and its participating Providers may not:
    - Discourage Member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a Provider who requests an expedited resolution or supports a Member's appeal;
    - Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    - Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a Member or to request Member disenrollment.
    - Safeguard the Member's right to confidentiality of information about grievance or appeal, except where the sharing of information is allowed for the purposes of treatment, payment or health care operations as defined in 42 CFR 164.501. The following pertains to the release of the Member's information:
- Yamhill CCO and any Provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use the information without the Member's signed release for purposes of:
    - Resolving the matter; or
    - Maintaining the grievance or appeals log as specified in 42 CFR 438.416.

- If Yamhill CCO needs to communicate with other individuals or entities not listed above to respond to the matter, Yamhill CCO will obtain the Member's signed release and retain the release in the Member's record.
- Safeguard Member's anonymity for protection against retaliation in the Member grievance and appeal resolution process.
- No incentivized compensation for utilization management activities by ensuring that individual(s) or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any Member.
- Cooperate with the Department of Human Services Governor's Advocacy Office, the Authorities Ombudsman and hearing representatives in all activities related to Member's appeals, hearing requests, and grievances including all requested written materials.
- All written grievance system information will be provided with the following guidelines:
    - Easily understood language and format;
    - Font size no smaller than 12 point;
    - Be available in alternative formats and through the provisions of auxiliary aids and services in an appropriate manner that takes into consideration with special needs of enrollees or potential enrollees with disabilities or limited English proficiency;
    - Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font no smaller than 18 point.
- Yamhill CCO will not take punitive action against any Provider who requests an expedited (fast) resolution or supports a Member's grievance or appeal.
- Members, an authorized representative, or a Provider with the written consent of the Member may file a grievance at any time either orally or in writing on behalf of a Member.
- Grievances may be filed directly with Yamhill CCO or with the Authority. If filed with the Authority, it will be forwarded to Yamhill CCO promptly.
- Yamhill CCO has 30 days to resolve all grievances.

Appeals

- Members, an authorized representative, or a Provider with the written consent of the Member may file an appeal at any time either orally or in writing on behalf of a Member.
- Appeal may be filed directly with Yamhill CCO or with the Authority. If filed with the Authority, it will be forwarded to Yamhill CCO promptly. The Member must exhaust the appeal process with Yamhill CCO prior to being eligible for a hearing.
- Appeals must be received within 60 days of the date of the denial letter (NOABD).

To file an appeal, send to:

Yamhill Community Care Grievance Specialist
PO Box 5490
Salem, OR 971304
Phone: 833-257-2192

Fax: 503-765-9675

Email: appeals@Yamhillcco.org

Expedited appeals are available when the standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860.

Claim denials are not eligible for an expedited appeal.

Appeal Timelines:

- Standard: 16 days with possible extension of 14 days.
- Expedited: 72 hours with possible extension of 14 days.

Hearings must be received within 120 days of the date of the appeal decision letter (NOAR). Hearings are requested by sending the request form included in the NOAR to:

OHA Medical Hearings
500 Summer St NE E49
Salem, OR 97301
Fax: 503-945-6035

The Member or Member's representative may also withdraw an appeal or contested case hearing request at any time.

If Yamhill CCO fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Member is considered to have exhausted the CCO's appeal process. In this case, the Member may initiate a contested case hearing.

Yamhill CCO ensures Members receive continuing benefits when requested and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending.

When a Provider files an appeal on behalf of a Member, the Provider may subsequently request a contested case hearing on behalf of the Member in accordance with the procedures in OAR 410-141-3900 and OAR 410-141-3905.

Grievance System Process, Policy and Rights Awareness and Sharing

Please note policies are subject to change when changes take place with the OHA CCO Contract or through Oregon and Federal Law. Policies will be updated as appropriate and Yamhill CCO will notify Providers of the updates via the Provider newsletter and the Yamhill CCO website, contact Yamhill CCO to ensure you have the most recent version. Copies of the Yamhill CCO Grievance System policies are located on the Yamhill CCO website.

For more information on this system, Members and Providers can contact Customer Service at 1-855-722-8205 for assistance.

American Disabilities Act (ADA), Cultural Considerations & Non-Discrimination

Yamhill CCO and all partners, staff and network Providers comply with applicable Federal civil rights laws and do not discriminate against, exclude, or treat people differently based on race, color, ethnicity, national origin, age, language, physical or mental disability, religion, sex, sexual orientation, and gender identity or expression.

File a complaint with Yamhill CCO by contacting:

Yamhill CCO
PO Box 5490
Salem, OR 97304

Phone: Call Section 1557 Coordinator at 833-257-2192 (TTY 711)

Fax: 503-765-9675

Email: Complaints@Yamhillcco.org

Members also have a right to file a complaint with any of these organizations:

Oregon Health Authority (OHA) Civil Rights

Attn: Office of Equity and Inclusion Division
421 SW Oak St., Suite 750
Portland, OR 97204

Phone: 844-882-7889, TTY 711

Email: OHA.PublicCivilRights@odhsoha.oregon.gov

Bureau of Labor and Industries Civil Rights Division

800 NE Oregon St., Suite 1045
Portland, OR 97232

Phone: 971-673-0764

Email: BOLI_help@boli.oregon.gov

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

Attn: Office for Civil Rights
200 Independence Ave.
SW, Room 509F, HHH Bldg.

Washington, DC 20201

Phone: 800-368-1019, TDD: 800-537-7697

Email: OCRComplaint@hhs.gov

Understanding the demographics of the population served and how those demographics are reflected in the staff and Providers in the agency serving them is an important component of discrimination and equitable provision of service. Providers will be expected to collect REALD demographics (race, ethnicity, age, language and disability) about their Yamhill CCO Member population and staff according to REALD requirements of House Bill 2134.

Yamhill CCO participates in the state's efforts to promote delivery of services in a culturally competent manner to all Members, including those who prefer a language other than spoken English and diverse cultural and ethnic backgrounds. Including but not limited to the following:

- Procedures for communicating with Members who have difficulty communicating due to a medical condition or living in a household where there is no adult available to communicate in English or there is no telephone;
- Certified or qualified interpreter services by phone or in person;
- Coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the Member's care; and
- Compliance with the requirements of the Americans with Disabilities Act of 1990, including but not limited to street level access or accessible ramp into the facility and wheelchair access to the lavatory.

Member Discrimination Prohibition

Members enrolled with Yamhill CCO shall not be denied care or assistance because of race, color, or national origin. The Office for Civil Rights (OCR) in the U.S. Department 14 of Health and Human Services (DHHS) enforces Title VI of the Civil Rights Act of 1964 as implemented by regulations of CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

Yamhill CCO and contracted partners and Providers shall not discriminate, as defined under this policy, against any Member(s).

For purposes of this policy, discrimination against a Member may include, but is not limited to:

- Denying any covered service or availability of a facility;

- Subjecting a Member to segregation or separate treatment in any manner related to the receipt of the covered service;
- The assignment of times and places for the provision of services on the basis of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, except where medically indicated.

Yamhill CCO and contracted partners and Providers shall not discriminate against a Member based on:

- Health status;
- Requirements for health care services during enrollment, re-enrollment, or disenrollment; or
- Adverse change in health status or receive termination of coverage based on this status.

All Yamhill CCO staff, partners and network Providers will comply with the requirements of the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehabilitation Act of 1973 and all amendments to those acts and all regulations declared thereunder.

Yamhill CCO will ensure that all Yamhill CCO staff, partners and network Providers have implicit bias; structural barriers and systemic oppression; CLAS (culturally and linguistically appropriate services including language access, interpretation, and health literacy); Adverse Childhood Experiences and historical trauma; ADA and accessibility; and REALD (race, ethnicity, age, language, and disability) training.

Native Rights

American Indians and Alaska Natives have a right to choose where they get care. They can use primary care Providers and other Providers that are not part of our CCO, like:

- Tribal wellness centers.
- Indian Health Services (IHS) clinics.
- Native American Rehabilitation Association of the Northwest (NARA)

These Members can use other clinics that are not in our network.

American Indian and Alaska Natives don't need a referral or permission to get care from these Providers. These Providers must bill Yamhill CCO. We will only pay for covered benefits. If a service needs approval, the Provider must request it first.

American Indian and Alaska Natives have the right to leave Yamhill CCO any time and have OHP Fee-For-Service (FFS) pay for their care.

If a Member wants to know if they are American Indian or Alaska Native, contact OHP Customer Service at 800-699-9075 (TTY 711) or they can login to their online account at ONE.Oregon.gov to report this.

They may be assigned a qualifying tribal status if any one of the following are true. These questions are also asked on the OHP application:

- They are an enrolled Member of a Federally Recognized Tribe or a shareholder in an Alaska Native Regional Corporation.
- They get services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics.
- They have a parent or grandparent who is an enrolled Member of a Federally Recognized Tribe or a shareholder in an Alaska Native Regional Corporation or Village.

Religious or Moral Objections

Yamhill CCO does not limit services based on moral or religious objection.

Confidentiality of Information

In accordance with all applicable state and federal laws, any Member information is required to be kept confidential. Additional information on ADA and non-discrimination may be found in the Yamhill CCO Member Non-Discrimination/ADA Policy and Procedure.

Restraint and Seclusion in Delivery of Health Care

Yamhill CCO ensures Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in federal regulations on the use of restraints and seclusion.

Medical Record Documentation Policies

Participating Providers are required to safeguard Member-identifying information and to maintain records in an accurate and timely manner consistent with state and federal laws. Compliance with medical record policies will be monitored by Yamhill CCO. By agreeing to participate, Providers agree to cooperate in random medical record reviews conducted by Yamhill CCO.

If evidence of substandard medical record keeping is identified by random chart note review, the Provider will be educated regarding this policy and further monitoring done as deemed necessary. Participating Providers may be required to submit Risk Response Plans for non-compliant processes if continued evidence of substandard medical record keeping is identified by random chart note review.

Each Provider shall maintain the confidentiality of the medical record information, assuring that the contents of the medical record shall be released to authorized personnel only. This includes Yamhill CCO's designee or persons, as authorized by the Member in the Release of Information form. The Provider shall cooperate with Yamhill CCO and their representatives for the purposes of audits and the inspection and examination of medical records. Medical record information can be released to Yamhill CCO by the Provider without a HIPAA Authorization form signed by the Member, according to HIPAA regulations, if the disclosure is for treatment, payment, and healthcare operations.

The PCP is responsible for the maintenance of each Member's integrated medical record that documents all types of services delivered, both during and after office hours.

Participating Providers shall include the following in the medical record for all Yamhill CCO Members' medical records:

- A summary of preventive visits according to established protocols, basis of the diagnostic impression, Member's primary complaint sufficient to justify any further diagnostic procedures, and treatment or recommendations for return visits and referrals.
- The medical record shall be complete and legible. Each entry shall be dated, have a legible signature/initial and all pages identified with the Member's name. A complete record includes chart notes, nurses' notes, vital signs, medications, immunizations, and telephone message entries. This excludes problems on the problem list, prominent allergy notations and biographical or business information.
- Medical records shall be organized, uniform, detailed, current, and contain the securely attached record of one Member in each chart.

Declaration of Mental Health Treatment

"A Guide to Oregon's Declaration for Mental Health Treatment" was developed pursuant to Oregon Revised Statutes (ORS) 127.700 through 127.736. It was created to allow the Member to protect themselves when they are unable to make their own mental health treatment decisions. The Declaration for Mental Health Treatment form describes what kind of care the Member wants or does not want if they ever need that kind of care but are unable to make their wishes known. The Member can choose an adult to represent them. The Representative must agree to do so. The Representative

keeps a copy of the Declaration, and a copy is provided to the Member's PCP or mental health Provider.

The Declaration is only good for three (3) years and must be renewed. If the Member is incapable of making mental health treatment decisions during the 3 years, the Declaration will remain until the time - whenever that may be - that the Member regains capacity to make their own decisions. The Member can change or cancel the Declaration as long as they are still capable of understanding the information provided. A revised copy must be provided to the PCP, dental or mental health Provider. Only a court and two doctors can decide if the Member is not able to make decisions about their mental health treatment.

For more information on the Declaration for Mental Health Treatment, go to the State of Oregon's website.

If a Member's Provider does not follow their wishes in their Declaration for Mental Health Treatment they can complain.

Send complaints to:

> **Health Care Regulation and Quality Improvement**
> 800 N.E. Oregon St., #465
> Portland, OR 97232
>
> Phone: 971-673-0540 (TTY: 971-673-0372)
>
> Email: Mailbox.HCLC@odhsoha.oregon.gov
> Fax: 971-673-0556

Declaration of Mental Health Treatment forms can be found on the Yamhill CCO website.

Advanced Directives (Living Wills), Portable Orders for Life Sustaining Treatment (POLST)

An Advance Directive, also called a Living Will, explains the specific medical decisions the Member wants if they have a terminal illness or injury and are incapable of making decisions about their own care, including refusing treatment. Most hospitals, nursing homes, home health agencies and HMOs (Health Maintenance Organizations) routinely provide information on advance directives at the time of admission. To comply with the Federal Patient Self Determination Act (PSDA) 1990 42 U.S.C. 1395 cc (a) Subpart E, Yamhill CCO requires that PCPs, dental and mental health Providers ask Members if they have executed an Advance Directive or mental health treatment declaration. The Provider must document that fact in the Member's medical record, make a copy of the document and include it as part of their medical record.

In Oregon, the Health Care Decisions Act (ORS 127.505 - 127.660 and ORS 127.995) allows the Member to preauthorize a health care representative(s) or health care power of attorney, at least 18 years of age, to allow the natural dying process if he or she is medically confirmed to be in one of the

conditions described in his or her health care instructions. Yamhill CCO encourages PCPs, as part of the Member education and registration process, to annually ask if the Member has executed an Advance Directive. If so, a copy should be included in the medical record.

Members, under federal and Oregon law, have rights concerning their medical and mental health care, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive, POLST, or declaration for mental health treatment. Providers are required to have written policies concerning these rights with implementation of the rights of Members with a clear and precise statement of limitation per CFR 42 Subpart I 489.102 and OAR 410-141-3585. Advance Directives can be found on the Yamhill CCO website.

Members can make a complaint to the Health Licensing Office if their Provider does not follow their advance directive.

Contact:

Health Licensing Office
1430 Tandem Ave NE, Suite 180
Salem, OR 97301

Phone: 503-370-9216 (TTY users, please call 711)
Hours: Monday through Friday, 8 a.m. to 5 p.m. PT
Email: hlo.info@odhsoha.oregon.gov

Members can make a complaint to the Health Facility Licensing and Certification Program if a facility (like a hospital) does not follow their advance directive.

Contact:

Health Facility Licensing and Certification Program

800 NE Oregon Street

Suite 465
Portland, OR 97322

Email: mailbox.hclc@odhsoha.oregon.gov
Fax: 971-673-0556

Notice of Privacy Practices and HIPAA

The Notice of Privacy Practices explains Members' rights to keep their personal information private and rights about their records and how they can get access to them. The notice tells how Yamhill CCO uses their personal information and the laws in place that we must follow. If you want a copy of

our Notice of Privacy Practices, please call Customer Service at 855-722-8205 to request one be sent to you. You can also download one from our website.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects protected health information (PHI) and keeps it private. All participating Providers are required to comply with HIPAA Privacy and Security rules and regulations.

Change of Information

Please notify Provider Relations of any changes to your practice including:

- Billing address
- Closing practice date
- Mailing address
- Member/patient limits and restrictions
- Physical office address
- Status of your Membership with Yamhill CCO
- Tax ID and NPI (National Provider Identifiers) number
- Telephone number

Submit any changes by email to Providerrelations@Yamhillcco.org or in writing:

Yamhill CCO
Attn: Provider Relations
807 NE Third Street
McMinnville, OR 97128

Compliance

Yamhill CCO is dedicated to operating in accordance with its CCO Contract with the Oregon Health Authority, along with State, Federal and local rules and regulations. Furthermore, Yamhill CCO expects its Provider panel to operate with a high level of integrity to ensure compliance with regulations.

Yamhill CCO will not tolerate deceitful, wasteful, abusive, or other similarly inappropriate activities among any of those individuals or entities whom we employ, serve, or otherwise do business with. More importantly, Yamhill CCO takes the health and welfare of our patients, Members, and others we serve very seriously.

Yamhill CCO's Compliance Program documents can be requested by emailing compliance@Yamhillcco.org. Additionally, Yamhill CCO's Compliance Office can be reached, at the contact information listed below, if there are questions or concerns regarding requirements.

Code of Conduct and Ethics

Providers for Yamhill CCO are required to comply with Yamhill CCO's Code of Conduct and Ethics Program. This document provides a solid basis for Providers to understand the core values we hold ourselves to and provides guidance in conducting business with or on behalf of Yamhill CCO. To that end, Yamhill CCO will provide a copy of its Code of Conduct and Ethics document to Providers during the credentialing and contracting process and expect Providers to attest that they have read and understood this document.

Compliance Program and Fraud, Waste and Abuse Prevention Plan Handbook and Policies and Procedures

Yamhill CCO's Compliance and Fraud, Waste, and Abuse (FWA) Prevention Plan Handbook and all applicable policies and procedures, govern the operational elements of its Compliance Program and FWA Prevention Plan. Accordingly, Providers are expected to fully comply and follow the requirements established in the Compliance Program Manual and FWA Prevention Handbook and all applicable policies and procedures. These documents can be requested by emailing compliance@Yamhillcco.org.

Fraud Waste and Abuse

Yamhill Community Care takes fraud, waste, and abuse (FWA) very seriously, and is committed to conducting its business in a lawful and ethical manner which includes prevention of FWA. Yamhill CCO complies with all state and federal laws and regulations pertinent to fraud, waste, and abuse, including without limitation, the State and Federal False Claims Acts, Anti-Kickback Statute, and the

Health Insurance Portability and Accountability Act of 1996 (HIPAA). All potential or suspected (or both) violations are investigated and resolved. Reports about FWA can be made anonymously and reporters are protected under the applicable Whistleblower laws. More information about the Yamhill CCO Compliance and FWA Prevention Plan or to request a copy of the plan or policies pertinent to FWA contact Yamhill CCO Customer Service or by email info@Yamhillcco.org.

Examples of FWA include but are not limited to:

- Someone using another person's insurance coverage for services.
- A Provider billing multiple times for one service, billing for a more costly service than performed, unbundling a service event to gain a larger payment, or charging a Member for a service they did not perform.
- A Provider ordering excessive or inappropriate tests, prescribing medications that are not medically necessary, or falsifying a diagnosis.
- A patient obtaining medications or products that are not needed and selling them on the black market or doctor shopping to obtain more medications.
- An insurer misleading enrollees about health plan benefits or denying valid claims.
- Undervaluing the amount owed by the insurer to a health care Provider under the terms of its contract.

Training

As a contracting condition, Providers must complete certain trainings for Yamhill CCO to meet contractual and regulatory requirements.

This training should be conducted on an annual basis and cover the following:

- Applicable administrative rules and Yamhill CCO policies
- Fraud, waste, and abuse, including the Yamhill CCO FWA Prevention Handbook (policies and procedures)
- Oregon Medicaid-specific reporting requirements and time frames
- HIPAA
- Correct billing practices and mechanisms for a Provider to report and return overpayments

- False Claims Act, Oregon False Claims Act, Oregon's Medicaid fraud statute, prohibition on making false statements, Civil Monetary Penalties, and Whistleblower protection.

- Anti-Kickback Statute and Physician Self-Referral Law
    - The credentialing and enrollment of Providers and subcontractors. The prohibition of employing, subcontracting, or otherwise being affiliated with (or any combination or all of the foregoing) with sanctioned individuals.
    - Credentialing staff and Subcontractors responsible for credentialing Providers and subcontracting with third parties are required to receive additional training related to credentialing, exclusion, screening requirements, and enrollment of Providers and Subcontractors. Yamhill CCO provides training or ensures the training includes material related to:

        - 42 CFR §§ 438.608(b) and 438.214(d) (i.e., disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs) and
        - screening requirements (i.e., identification of moderate to high-risk Providers, verification of Medicaid enrollment with OHA prior to credentialing).
- Trauma informed care

Yamhill CCO shall require and provide training or ensure training is provided on implicit bias for all of the Provider network. Cultural Responsiveness and implicit bias training for the Provider network, at a minimum, includes:

- Implicit bias/addressing structural barriers and systemic oppression;
- Language access and use of health care interpreters;
- Culturally and Linguistically Appropriate Services (CLAS) Standards;
- Adverse childhood experiences/trauma informed care;
- Uses of data to advance health equity; and
- Universal access or accessibility in addition to ADA.
- Providers may elect to utilize their own training or request training from Yamhill CCO. If Providers intend to develop and utilize their own training, the Provider must ensure it aligns with the materials presented in:
    - CMS Medicare Learning Network
    - Yamhill CCO's contract with the Oregon Health Authority (Exhibit K).
    - OHA pre-approved trainings are available for use

Yamhill CCO reserves the right to require its Providers to attest and/or provide documentation that the Provider and its workforce has received the required training. In the event that a Provider cannot demonstrate training was provided, Yamhill CCO may ask the Provider to complete a Risk Response Plan to address the deficiency.

Prohibition of Excluded Individuals

Yamhill CCO is prohibited from engaging in any form of contractual relationship with individuals or entities who are actively excluded/debarred from participation in State and Federal healthcare programs. This requirement trickles down to its Providers, therefore, Providers are expected to comply with this requirement by ensuring they are not contracting or employing any individual who is actively excluded/debarred from State and Federal healthcare participation.

Commonly referred to as exclusion or sanction monitoring, Providers shall review monthly that none of their employees or contractors are actively listed on the following databases:

- HHS-OIG's List of Excluded Individuals (LEIE).
- Excluded Parties List System (EPLS), also known as System for Award Management (SAM).

In the event a Provider identifies an individual who is actively excluded/debarred, the Provider shall notify Yamhill CCO's Compliance Department within one business day.

Cooperation with Compliance Activities

Yamhill CCO engages in various activities supporting its Compliance Program. Providers and their staff must fully cooperate with all Yamhill CCO Compliance activities.

Such activities include but are not limited to:

- External audits
- Provider audits
- FWA audits, including claims and billing audits
- Subcontractor audits
- Investigations
- Training

In the event Yamhill CCO identifies deficiencies associated with a Provider's performance, Yamhill CCO will engage in a Corrective Action Plan process with the Provider. Providers are expected to participate and take appropriate actions to mitigate any deficiencies promptly.

Yamhill CCO Policies and Procedures

Please note policies are subject to change when changes take place with the OHA CCO Contract or through Oregon and Federal Law. These policies will be updated as appropriate. Active policies are available online via PolicyCo. If you have any questions regarding a Yamhill CCO Policy and Procedure, please contact Yamhill CCO Customer Service at 855-722-8205 or send the request via email at info@Yamhillcco.org.

Reporting Concerns

Individuals and Providers who suspect fraud, waste, or abuse or other suspicious activities, are required to report these concerns to Yamhill CCO's Compliance Department. If identification of Overpayment was the result of self-reporting to Contractor by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR § 401.305, such Overpayment to Contractor within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment.

Furthermore, Yamhill CCO expects its Provider panel to comply with its Non-Retaliation Policy for individuals who report matters in good faith.

Reports can be made to:

Yamhill CCO
Attn: Compliance Department
807 NE Third St
McMinnville, OR 97128
Hotline Phone: 844-989-2845

Yamhill CCO reports all suspected fraud, waste, and abuse to the appropriate agencies. You can also report fraud, waste, and abuse directly to the Oregon Department of Human Services, Oregon Health Authority, or Oregon Department of Justice:

To report **Member** fraud contact:

ODHS Fraud Investigation Unit
P.O. Box 14150
Salem, OR 97309

Hotline: 1-888-FRAUD1 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline

To report **Provider** fraud contact:

OHA Office of Program Integrity (OPI)
500 Summer Street N.E.
Salem, OR 97301

Phone: 1-888-FRAUD1 (888-372-8301)
Fax: 503-378-2577
Secure email: OPIReferrals@oha.oregon.gov

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201

Phone: 971-673-1880
Fax: 971-673-1890
Secure email: Medicaid.Fraud.Referral@doj.state.or.us

US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489 Washington, DC 20026

Phone: 800.HHS.TIPS (800.447.8477)
Fax: 800.223.8164