Provider Manual



Healthier Together

Samaritan Health Plans

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Section 1: Introduction

1.1 About us

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

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

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

Mission

Building Healthier Communities Together

Vision

Serving our communities with PRIDE.

Values

Passion
Respect
Integrity
Dedication
Excellence

1.2 About this manual

Samaritan Health Plans has developed this manual for our contracted providers. The Provider

Manual, along with your contract, will offer guidance and resources to aid you in providing care to SHP members and your patients. This manual provides crucial information concerning the role and responsibilities of the provider in the delivery of health care to our members and your patients. The Provider Manual is updated quarterly and is an extension of your contract with SHP and InterCommunity Health Network Coordinated Care Organization. This document is located at samhealthplans.org/ProviderManual.

In addition, SHP's provider website offers helpful tools such as provider directories, member benefits and current announcements.

1.3 Lines of business

Samaritan Advantage Health Plans

Samaritan Advantage Health Plans HMO (SAHP) offers four plans to eligible members: Valor, Premier Plan, Premier Plan Plus and Dual Advantage.

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

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

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

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

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

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

Providers contracted with SAHP can be found through a searchable directory.

SAHP members have rights and responsibilities as described in the "Your rights and responsibilities" chapter of the Evidence of Coverage. You can also find this information in the member rights and responsibilities section of this manual.

InterCommunity Health Network CCO

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

IHN-CCO offers three benefit packages for members, depending on the level of care individual members need: comprehensive (medical, behavioral health and dental), behavioral health and dental and behavioral health only.

IHN-CCO uses the OHP Prioritized List of Health Services, a listing of diagnosis and treatment pairings, to determine whether a diagnosis and/ or service is part of the OHP benefit package. The Oregon Health Services Commission designs and maintains the prioritized list under the direction of the Oregon Legislature. The legislature determines the level to which the list will be funded. Diagnoses and/or treatments that are considered **below the line** are not funded by the available budget set forth by the Oregon Legislature and are therefore not considered part of the OHP benefit package. IHN-CCO plan benefits are subject to review for medical necessity via written documentation, appropriateness of treatment setting (level of care versus severity of condition) and the OHP Prioritized List condition/treatment pair ranking.

Providers contracted with IHN-CCO can be found through a searchable directory.

IHN-CCO members have rights and responsibilities as described in the IHN-CCO Member Handbook. You can also find this information in the member rights and responsibilities section of this manual.

Samaritan Choice Plans

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

Samaritan Choice Plans offers a standard medical PPO plan, an HSA-eligible high-deductible medical plan and a vision plan. A pharmacy plan is included with both medical plans. Up-to-date plan benefits can be found in the Samaritan Choice Summary of Benefits and Coverage for each individual plan.

Preferred providers for Samaritan Choice Plans can be found through a searchable directory.

Samaritan Choice members have rights and responsibilities as described in the Samaritan Choice Plans Member Handbook.

Samaritan Employer Group Plans

Samaritan Health Plans offers employer group health plans to businesses domiciled in the state of Oregon. Up-to-date plan benefits are listed on the SHP website for Small, Large and Association groups.

Preferred providers for Samaritan Employer Group Plans can be found through a searchable directory.

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

Section 2: Contact us

Prior to contacting Provider Relations or the SHP Customer Service team, please utilize the SHP provider portal for issues related to:

A. Member eligibility and benefits.
B. Claims status (it may take up to 14 days for a received claim to appear in the portal).
C. Authorization submission and approval verification.

Provider Services

The SHP Provider Relations team is here to assist you with:

A. Credentialing and recredentialing questions.
B. Contracting (existing or new).
C. Provider education and training.
D. Samaritan Health Plans provider portal.

Provider Relations email:

shpprovider@samhealth.org.

Customer Service

The SHP **Customer Service** team is available to assist our providers Monday through Friday, from 8 a.m. to 8 p.m. PST.

Phone:

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

Mail:

Samaritan Health Plans
PO Box 1310
Corvallis, OR 97339

Walk-in:

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

Section 3: Claims

3.1 Eligibility and benefits

Eligibility and benefit information for members should be accessed via SHP's Provider Connect portal. Except for emergency services and as applicable, the provider must verify each member's eligibility prior to rendering any services. Providers may contact SHP Provider Services with questions.

3.2 General claims information

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

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

3.3 Oregon Medicaid provider enrollment

The Oregon Health Authority requires all providers who submit claims to Oregon Coordinated Care Organizations to be enrolled with the Oregon Medicaid office prior to receiving payment for services. If you have not enrolled, you must submit application materials and receive an Oregon Medicaid ID number before SHP can pay you.

3.4 Electronic claims submission

SHP encourages providers to submit claims via Electronic Data Interchange for quicker claims reimbursement, improved accuracy and to reduce or eliminate costs associated with mailing, such as envelopes and postage. Electronic submission of coordination of benefits claims is also encouraged. To sign up for EDI, visit SHP's billing and claims page.

3.5 Electronic funds transfer

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

A. Accelerated access to funds with direct deposit into your existing bank account.
B. SHP administrates payments for IHN-CCO. By signing up for EFT, you will receive SHP payments and those for the IHN-CCO members you see.
C. Reduced administrative costs by eliminating paper checks and remittances.

SHP has partnered with InstaMed to deliver this simplified payment experience. To sign up and begin receiving electronic funds transfers, contact InstaMed at:

Online: Visit InstaMed.com/ERAEFT
Phone: Call InstaMed at **866-945-7990** to speak with an agent.

3.6 Electronic remittance advice

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

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

Online: Visit InstaMed.com/ERAEFT
Phone: Call InstaMed at **866-945-7990** to speak with an agent.

3.7 Paper claims submission

Electronic claims submission is encouraged (refer to Section 3.4). However, providers who submit paper claims should refer to the following standards to produce clean and legible claims, which will reduce claim rejection and processing times, and prevent payment delays.

If you need help filling out the CMS 1450 or 1500 form, please visit SHP billing and claims submission and choose File by Mail for billing tips and guides.

A. Submit only claim forms that are typed or printed.
B. Correctly align text in the form boxes and do not allow text to overlap lines.
C. All claims and attachments should be printed single sided. Do not duplex print, even on primary Explanation of Benefits or attachments.
D. Send full page attachments only.
E. Do not staple claims or attachments together.
F. Mark multi-page claims with either a page number, e.g., page 2 of 3, or mark pages as “continued”.
G. Ensure that each secondary claim has the primary EOB submitted with it.
H. Do not write or stamp over top of the body of the claim form.
I. Do not use white-out or cross out and correct any fields that affect the payment of the claim.

J. Use black ink; the claims scanning process will filter out red ink.
K. Use the remarks field for messages.
L. Send the original claim form to Samaritan Health Plans and retain a copy for your records.
M. To help the equipment scan accurately, remove all perforated sides from the form. Leave a quarter-inch border on the left and right sides of the form after removing perforated sides.
N. Do not highlight any fields on the claim forms or attachments. Highlighting makes it more difficult to create a clear electronic copy when the document is scanned.
O. Print with dark font. Ensure your toner or ink is fresh and please do not print in draft mode.

Where to mail paper claims

Please visit SHP billing and claims submission and choose File by Mail to access SHP's mailing addresses by line of business. If you submit paper claims, the following information must be included:

A. Provider name.
B. Rendering provider and group or billing provider.
C. Federal provider TIN.
D. NPI (excluding atypical providers).
E. Medicare number (if applicable).
F. DMAP number (if applicable).

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

3.8 Monitoring submitted claims

Claims status will be available in SHP's provider portal after submission of any clean claim. Clean paper claims will be available for monitoring within 10 to 14 days of receipt. Clean electronic claims will be available for monitoring within two days of receipt.

Clean claims take up to 30 days to process, per SHP policy and state and federal regulation. After submitting claims, you can monitor them by:

A. Checking claim status on SHP's secure provider portal. Users must be subscribers of OneHealthPort to login. If you are not yet subscribed to OneHealthPort, please register your organization. Providers that are not subscribed should click on “I’m not an OneHealthPort Subscriber but would like information on subscribing.”
B. Contacting Provider Services. Contracted providers are asked to verify claim status using the provider portal, per the instructions above, prior to contacting SHP Provider Services.

Please keep in mind, it may take up to 14 days for a submitted claim to appear in the provider portal.

C. Confirming receipt of plan batch status reports from your vendor or clearinghouse to ensure your claims have been accepted by SHP.
D. Correcting and resubmitting plan batch status reports and error reports electronically.
E. Correcting errors and immediately resubmitting to prevent denials due to late filing.

3.9 Claims editing and pricing

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

SHP utilizes both the Optum EASYGroup Prospective Payment Systems and the Claims Editing System software to ensure accuracy and consistency in claims processing for all SHP's product lines for both professional and facility-based claims. This software applies all existing industry standard criteria and protocols for Diagnosis Related Groups (DRG), Current Procedural Terminology (CPT), Healthcare Procedure Coding System (HCPCS) and the Internal Classification of Diseases (ICD-10-CM) manuals.

The three most prevalent coding irregularities are:

A. **Unbundling**: Two or more individual CPT or HCPCS codes that should be combined under a single code or charge.
B. **Mutually exclusive**: Two or more procedures that by practice standards would not be billed to the same patient on the same day.
C. **Inclusive procedures**: Procedures that are considered part of a primary procedure and not paid as separate services.

Consistent application of these rules improves the accuracy and fairness of SHP's payment of benefits.

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

Samaritan also reviews all high-dollar claims prior to processing as part of its payment integrity program. These claims are reviewed against coding and billing requirements and to ensure all

services provided were covered according to the member's plan and meet medical necessity requirements.

3.10 Coding

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

3.11 Prompt payment

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

A. Medicare Managed Care Appeals & Grievances webpage.
B. Medicare Claims Processing Manual Chapter 1, Sections 80.2 and 80.3.
C. Prioritized List and Guideline Notes.

3.12 Third-party liability

SHP follows the National Association of Insurance Commissioners (NAIC) model regulations for coordinating benefits, except in instances where the NAIC model regulations differ from Oregon state law or from CMS regulations. The timely filing deadline for all third-party liability claims is 365 days from the date of service on the claim. To meet these requirements, Samaritan Health Plans has partnered with The Rawlings Company to provide subrogation and workers' compensation claim recovery.

The purpose of the Subrogation and Workers' Compensation program is the recovery of paid claims related to a third-party liability (TPL) event. Examples of TPL include motor vehicle accidents, product liability cases or work-related injuries and illnesses.

When information is received by a provider that indicates a SHP member was involved in a possible TPL event, please contact The Rawlings Company directly at **877-229-1117** or SamaritanHealthReferrals@rawlingscompany.com.

3.13 Balance Billing

Samaritan Advantage Health Plans

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

coinsurances and copayments. Federal law prohibits all Medicare providers from billing QMBs for all Medicare deductibles, coinsurance, or copayments. All Medicare and Medicaid payments you receive for furnishing services to a QMB are considered payment in full.

InterCommunity Health Network CCO

A provider who is rendering services to an IHN-CCO member:

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

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

A. Any applicable coinsurance, copayment and deductibles expressly authorized in OAR 410-120 and OAR 410-141, or any other Division program rules.
B. The member did not inform the provider of their OHP coverage at the time of or after service was provided. Therefore, the provider could not bill the appropriate payer for reasons including, but not limited to, the lack of prior authorization or the claim exceeding the timely filing limit. The provider must verify member eligibility and document their attempts to obtain coverage information prior to billing the member.
C. The member became eligible for benefits retroactively but did not meet all the criteria required to receive the service.
D. A third-party payer made payments directly to the member for services provided.
E. The member has the limited Citizen Alien Waived Emergency Medical (CAWEM) benefit package. CAWEM members have the benefit package identifier of CWM. Members receiving CAWEM benefits may be billed for services that are not part of the CAWEM benefits (see OAR 410-120-1210 for coverage). The provider must document that the member was informed in advance that the service or item would not be covered by the Division. An OHP 3165 is **not** required for these services.
F. The member has requested a continuation of benefits during the contested case hearing process, and the final decision was not in favor of the member. The member shall pay for any charges incurred for the denied service on or after the effective date on the Notice of Action or Notice of Appeal Resolution. The provider must complete the OHP 3165 pursuant to section (5)(h) of OAR 410-120-1280 before providing these services.
G. In exceptional circumstances, a member may decide to privately pay for a covered service. In this situation, the provider may bill the member if the provider informs the member in advance of all the following:
    1. The requested service is a covered service and the appropriate payer (the Health Systems Division, Managed Care Entity (MEC) or third-party payer) would pay the

provider in full for the covered service. The estimated cost of the covered service, including all related charges, the amount that the appropriate payer would pay for the service and that the provider cannot bill the member for an amount greater than the amount the appropriate payer would pay.

2. The member knowingly and voluntarily agrees to pay for the covered service.
3. The provider documents in writing, signed by the member or the member's representative, indicating the provider gave the member the information described in section (5)(g)(A-C) of OAR 410-120-1280; that the member had an opportunity to ask questions, obtain additional information and consult with the member's caseworker or representative; and that the member agreed to privately pay for the service by signing an agreement incorporating all the information described above. The provider must give a copy of the signed agreement to the member. A provider may not submit a claim for payment for covered services to the Division or to the member's MCE or third-party payer that is subject to the agreement.

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

3.14 Samaritan Advantage Benefits MasterCard

Samaritan Advantage members are given a Benefits MasterCard to use for payment for certain services. Rather than billing the plan, members should use their Benefits MasterCard to **pay directly for the following services**:

A. Preventive and comprehensive dental services, e.g., exams, cleanings, X-rays, fillings, periodontal services, or extractions.
B. Routine vision hardware, e.g., glasses, frames, contact lenses, or upgrades like scratch-resistant coating.
C. Hearing aids, e.g., hearing aids, hearing aid supplies, or repairs.

The plan should be **billed directly for the following services** that the benefits card does **not** cover:

A. Medicare-covered dental care, e.g., services by a dentist or oral surgeon, limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, or services that would be covered when provided by a doctor.
B. Vision exams and glaucoma screenings.
C. Eyeglasses or contact lenses after cataract surgery.

D. Hearing exams, unless the cost of a hearing aid fitting or evaluation is included in the hearing aid cost.

A member's balance can be verified by calling the number on the back of the card or by logging into the EBC portal, accessible via MyHealthPlan. It is helpful for members to know the balance available before running the card. The card may not work if processed for more than the available balance. The amount available for each benefit depends on the member's enrolled SAHP plan.

Additional information about the benefits card can be found on the SHP website.

3.15 Timely filing

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

Samaritan Advantage Health Plans

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

InterCommunity Health Network CCO

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

Samaritan Choice Plans

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

Samaritan Employer Group Plans

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

Section 4: Utilization management

The Utilization Management (UM) and Pharmacy Departments are integrated within the Clinical Services Division. Utilization review is conducted according to department policies, procedures, clinical criteria and clinical practice guidelines. Medical necessity is determined, and the decision time frame and notifications must adhere to practice and plan documents. The scope of review includes all behavioral and physical health, including inpatient admissions to hospitals, acute rehabilitation facilities, skilled nursing facilities, home health services, durable medical equipment, outpatient care, provider administered drugs and office visits.

4.1 Utilization management

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

4.2 Utilization management disclaimer

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

4.3 Inpatient Notification Requests

Samaritan Health Plans requires inpatient notification requests to be submitted via the SHP provider portal. If you do not have access to the provider portal, please refer to Section 13.4 of this manual for further assistance.

Emergency Services do not require prior authorization in accordance with the Patient Protection and Affordable Care Act. However, as a condition of payment, SHP requires notification for any

member who is being admitted for inpatient care. Both admitting practitioners and facilities are responsible for following the procedures as outlined below and in accordance with the applicable time frames:

A. Notifications must be submitted via fax within 24 hours of admission or next business day for weekend or holiday admissions.
B. Observation stay notifications should be sent as soon as the stay exceeds 48 hours or within 24 hours of the inpatient order.
C. All inpatient notifications are subject to concurrent review and continued stay review.
D. information must be received within 48 hours following the request.
E. Inpatient notifications should include the following:
    1. Member demographic information.
    2. Member date of birth.
    3. Member ID.
    4. ICD-10-CM codes.

Incomplete or late notifications may cause a delay in coordination of care and result in an administrative denial of care that was provided prior to the date the complete notification is received.

If you have additional questions or need assistance, please contact SHP Provider Services following the guidelines in Section 2 of this manual.

4.4 Authorizations

Utilization Management and Pharmacy ensure accurate and timely processing of prior authorization related to durable medical equipment, medical procedures, provider administered drugs and services for mental health and substance use disorder. Utilization Management and Pharmacy verify that appropriate clinical information is obtained, documented and reviewed for all decisions. This process may include consulting with the requesting provider when appropriate.

Contracted providers are required to submit authorization requests for medical procedures through Provider Connect. Authorization requests for outpatient provider- administered drugs must be submitted through the Optum Specialty Fusion platform or by calling **800-385-3593**.

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

A. **Expedited**: Submission must indicate that waiting for a decision within the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy. Appropriate clinical information is required to be attached at the time of the expedited request.

B. **Retroactive**: Utilization Management and Pharmacy follow state and federal regulations and contract language for review of retroactive authorization requests. Contracted providers may submit retroactive requests for physical and behavioral health services within 90 calendar days from the date of service for IHN-CCO, Samaritan Choice and Samaritan Employer Group plans. Retro requests received after 90 days will be dismissed. Retroactive authorization requests submitted by non-contracted providers and facilities will be accepted and processed in accordance with the specific authorization request policy for the lines of business identified above, up to one year from the date of service. Samaritan Advantage plans do not accept retroactive authorization requests from neither contracted nor non-contracted providers.

4.5 Clinical criteria

The plan's evidence of coverage, member handbook or certificate plan document along with federal and state guidelines are used to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines and company-developed clinical standards are used to determine clinical and medical appropriateness of services.

The criteria are selected, developed, approved and overseen by the Utilization Management committee. This committee will ensure clinical consistency and appropriateness of all criteria utilized by the UM team. Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

The criteria include:

A. MCG CareWebQI – assessment tools, review criteria and reporting.
B. Centers for Medicaid and Medicare Services (CMS) Medicare Coverage Database, a compendium of regulations, operation policy letters and manuals that are based on medical appropriateness criteria and clinical status of the patient to support decision-making.
C. Samaritan Health Plans' medical coverage policies, which are based on local, regional and national practice standards, literature, research and consensus-based policy.
D. The Oregon Health Plan, Oregon Administrative Rules and Oregon Revised Statutes provide guidance for interpreting IHN-CCO Medicaid benefits.
E. Oregon Health Authority Prioritized List of Health Care Services along with Guideline Notes.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity, complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria. The organization gives practitioners who have clinical expertise in the area being reviewed the opportunity to advise or comment on the development or adoption of criteria.

4.6 Medical coverage policies

Medical coverage policies provide clinical criteria for decision-making and are developed when no appropriate external guidelines exist. Medical coverage policies do not determine covered benefits or whether a prior authorization is required. Current medical coverage policies are available for UM at SHP's Care Coordination web page under medical coverage guidelines and for Pharmacy at SHP's Find a Drug web page.

4.7 Peer-to-peer consultation

Treating providers may request a peer-to-peer consult with SHP Medical Review to discuss the reason(s) for a specific denial or adverse benefit determination of services or items. Peer-to-peer consults may be requested via fax at **541-768-9766** or email to SHPPeerToPeer@samhealth.org.

A peer-to-peer consultation is not intended to overturn a previously denied authorization request but instead takes place after an adverse benefit denial has occurred. The discussion gives the requesting provider the opportunity to discuss the case and criteria for approval with the SHP medical director who issued the denial. Providers have five business days after the issuance of a denial letter to request a peer-to-peer.

4.8 Referrals for out-of-network services

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

All authorization requests submitted by non-contracted providers and facilities will be accepted and processed in accordance with the authorization request policy specific to the line of business.

Providers are responsible for referring SHP members only for services that are covered by CMS or Samaritan Health Plans.

Referrals made for IHN-CCO members must be made to a Medicaid participating provider. There are a few exceptions in which an IHN member can see a non-contracted provider without getting approval in advance. These are:

A. Ambulance and emergency room services (for emergencies).
B. Women's health specialists.
C. Family planning.
D. Some immunizations.

4.9 Referral not required

Referrals are not required for the following; however, these services are subject to plan benefits and eligibility:

A. Annual women’s exam.
B. Anticoagulation office visits.
C. Certain immunizations (may be given by any provider).
D. Emergency care.
E. Family planning services and supplies and choosing the method of family planning to be used (may be given by any provider)*.
F. Prescription and over-the-counter contraception.
G. Health Department services.
H. Care coordination services.
I. Lactation services.
J. Maternity care — a referral from the PCP is needed to see a specialist other than a maternity doctor.
K. Members in a designated special needs rate group (e.g., HIV).
L. Mental or behavioral health care services.
M. Routine vision exams.
N. School-based health center services.
O. Substance use disorder treatment services (drug and alcohol treatment services).
P. Urgent care.
Q. Women's health specialist (e.g., gynecologist, etc.) for routine and preventive women's health care services. This is in addition to their PCP when that PCP is not a women's health specialist. Non-PCP family planning services include, but are not limited to, the following:
    1. Annual exams.
    2. Contraceptive education and counseling to address reproductive health issues.
    3. Prescription contraceptives (such as birth control pills, patches or rings).
    4. IUDs and implantable contraceptives, and the procedures required to insert and remove them.
    5. Injectable hormonal contraceptives (such as Depo-Provera).
    6. Prescribed pharmaceutical supplies and devices (such as male and female condoms, diaphragms, cervical caps and foams).
    7. Laboratory tests include appropriate infectious disease and cancer screenings.
    8. Radiology services.
    9. Medical and surgical procedures, including vasectomies, tubal ligations and abortion.

Per CCO contract, the CCO is not responsible for covering abortion services. The CCO is responsible for covering services related to managing a miscarriage or complications following an abortion.

4.10 Early and periodic screening, diagnostic and treatment services

As of Jan. 1, 2023, the Oregon Health Authority and coordinated care organizations are required to cover the full scope of early and periodic screening, diagnostic and treatment services, also known as EPSDT, for children from birth until their 21st birthday. Under EPSDT, the Oregon Health Plan covers medically necessary and medically appropriate services for enrolled children and youth until their 21st birthday, regardless of the Prioritized List. Providers should submit documentation supporting medical necessity and medical appropriateness with any request for authorization.

4.11 Young adults with special heath care needs

Beginning Jan. 1, 2025, Oregon will offer a new Medicaid eligibility category called Young Adults with Special Health Care Needs (YSHCN), giving individuals who are part of this population access to special Oregon Health Plan benefits. YSHCN-eligible individuals are aged 19 through 25 years, with an income up to 205% the federal poverty level, and have qualifying health care needs as approved in the 1115 Medicaid waiver special terms and conditions. This eligibility expansion will be implemented on a rolling basis by age group starting with 19- and 20-years-olds in 2025. Examples of qualifying health care needs include physical, intellectual and developmental disabilities; long-standing physical health conditions like asthma, diabetes, or spina bifida; and behavioral or mental health conditions like depression or substance use disorder.

4.12 Out-of-state services

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

Section 5: Care management

5.1 Care management services

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

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

Care coordination

Care Coordination is a care management program for members on IHN-CCO who may have special health care needs. Examples include:

A. Physical, functional, intellectual or developmental disabilities.
B. Long-standing or chronic medical condition(s).
C. Complex behavioral health conditions, including substance use disorders or serious and persistent mental illness.
D. Health or social conditions placing them at risk that, without intervention, will likely cause negative impact to an individual's health or wellbeing.

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

Members are identified through direct referrals from contracted providers, community partners who are directly engaged with the member, referrals from utilization management, data analysis, members and member representatives. Once a member agrees to participate in care coordination services, the clinical care managers complete interventions such as:

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

Care management staff are assigned to support the member in developing an individualized care plan (ICP). This may begin by completing a health assessment. The ICP is created by and for the member to positively impact health outcomes.

The ICP addresses the member's clinical and social needs identified during the assessment or from the member and tracks the member's identified goals to overcome barriers. Behavioral health providers assess for adverse childhood experiences, trauma and resiliency when developing the ICP. The ICP is supported by the members interdisciplinary care team. The team consists of internal and external health professionals and social supports working together to coordinate the member's care. The interdisciplinary care team coordinates care and develops a plan of care for high-needs members.

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

Maternity case management

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

Getting to know the SHP care management team

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

Behavioral health care managers: The behavioral health care manager provides screening, knowledge of criteria and clinical judgment to assess patient needs and assure that medically appropriate treatment is provided in a quality, cost-effective manner within the benefit plan of the member. They participate in care coordination and discharge planning activities for members receiving mental health services and collaborate with community partners to identify member needs, support service delivery and close gaps in member care. This service includes discharge planning for short term, long term and institutional stays for mental health treatment in collaboration with the treating facility and may include the member's care team. They support

community efforts in establishing the Youth and Family System of Care and initiatives aimed at improving access to services and quality of care.

Behavioral health care coordinators: The behavioral health care coordinator provides members with care coordination interventions and seamless support across transitions of care. They work with members that have a low level of service intensity.

Community health workers (CHWs): CHWs work in collaboration with the clinical care team and community partners. They assist members in accessing health care by connecting members to their provider care team and helping them understand their health plan benefits, limits and guidelines. CHWs are integral in coordinating community supports and resources to promote healthy choices and improve social determinants of health and equity. Referrals can be made to several community programs such as education, transportation, utilities, food banks and housing programs to improve the conditions in a member's environment.

5.2 Advancing health equity

SHP is committed to the Oregon Health Authority's core values and goal of eliminating health inequities by 2030. Health disparities negatively affect people who historically and currently experience obstacles to health. Health disparities can include the following:

A. Racial or ethnic groups.
B. Religion.
C. Socioeconomic status.
D. Gender or gender identity.
E. Age.
F. Mental health.
G. Cognitive, sensory or physical disability.
H. Sexual orientation.
I. Geographic location.
J. Characteristics historically linked to discrimination or exclusion.

People who experience health disparities often have trauma, including generational trauma, that shapes how they engage with the health care system. Current medical systems and processes can retraumatize people leading to reduced engagement with the health care system, leading to poor health outcomes and lack of preventive care. For example, a transgender woman with a broken foot may not seek care due to being misgendered in their previous experience with the provider, leading to difficulties walking.

Even well-intentioned providers may have implicit or unconscious biases that impact their interactions with patients or clients. Understanding and acknowledging self-bias is integral to serving diverse patients or clients in a culturally responsive manner.

As a partner in service of SHP members, you can play a critical role in advancing health equity for all and eliminating health disparities.

Ways you can help advance health equity

A. Practice trauma-informed care:
   1. A trauma-informed approach to care shifts the narrative from what's wrong with you to what is the whole story of your health; trauma-informed providers recognize the ways in which health behaviors develop as coping responses and how to recognize, understand and respond to the effects of trauma. Trauma-informed care means providing culturally responsive care, engaging the patient in their own care, and developing a workforce that is trauma-informed. Trauma-informed care is valuing people's lived experiences and regarding them as subject matter experts and active participants in their own health and wellbeing.
   2. There are resources and training opportunities. Please contact SHP Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST if you want to be connected to any of the available resources.

B. Provide culturally humble and responsive care:
   1. Provide interpreters for all patients who need one. Additional information on interpreter services and meaningful language requirements enforced by the Oregon Health Authority can be found in Section 10.9 of this manual.

C. Screen patients for social determinants of health or contact SHP for any patient care needs. Contact the SHP Care Coordination team for any patient care needs or additional help.

D. Cultivate a culture of awareness and acceptance by recruiting and retaining diverse staff and providers.

Thank you for being a partner in advancing health equity and eliminating health disparities.

Available resources

SHP Provider Relations: shpprovider@samhealth.org

SHP Care Coordination: CareCoordinationTeam@samhealth.org

Health Disparities Resources for Providers from Harvard Medical School

Trauma Informed Oregon (TIO)

OHA Health Equity Committee (HEC)

How to contact Care Coordination

Phone: **541-768-4877**, Monday through Friday, from 8 a.m. to 5 p.m.
Fax: 541-768-9768

Email: CareCoordinationTeam@samhealth.org
Mail: Samaritan Health Plans
Attn: Care Coordination
PO Box 1310
Corvallis, OR 97339

Section 6: Dental services

6.1 Samaritan Advantage Health Plans

Any dental provider who has not submitted an opt-out affidavit to CMS can provide dental services to a Samaritan Advantage member and receive reimbursement. Samaritan Advantage members are given a Benefits MasterCard to pay for covered preventive and comprehensive dental services. Benefits cards are mailed to all active members and are automatically loaded with the value of their covered dental benefit, based on the plan in which they are enrolled.

Rather than billing the plan, members should use their Benefits MasterCard to pay directly for **preventive and comprehensive dental services**, e.g., exams, cleanings, X-rays, fillings, periodontal services, or extractions.

The plan should be billed directly for services that the benefits card does **not** cover. These include **Medicare-covered dental care**, e.g., services by a dentist or oral surgeon, limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, or services that would be covered when provided by a doctor.

The benefits card can be used at any dental provider office that accepts MasterCard, has not opted-out of Medicare and has a Merchant Category Code of 8021 (dentists, orthodontists). A member's balance can be verified by calling the number on the back of the card or by logging into the EBC portal, accessible via MyHealthPlan. It is helpful for members to know the balance available before running the card. The card may not work if processed for more than the available balance. The amount available for each benefit depends on the member's enrolled SAHP plan.

Additional information about the benefits card can be found on the SHP website.

6.2 InterCommunity Health Network CCO

Poor oral health has been linked to chronic pain, lost school and workdays, and avoidable visits to the emergency department. Oral health can also affect speech, nutrition, growth and function, and social development. Ensuring everyone has access to dental health care throughout their lifespan is important to your patient's overall health and quality of life.

Providers can engage patients in relevant oral health discussion with two simple questions:

A. Are you experiencing any dental pain?
B. Have you seen your dentist in the last six months?

Depending on how your patient answers these questions, you can refer them to their assigned dental plan. IHN-CCO partners with four dental plans to administer dental coverage and services

to your IHN-CCO patient panel. Each patient is assigned to their dental plan based on continuity of care, family assignment and county of residence.

IHN-CCO dental plans	Serves Benton County	Serves Lincoln County	Serves Linn County
Advantage Dental	☑	☑	☑
Capitol Dental Care	☑	☑	☑
ODS	☑	☑	☑
Willamette Dental Group	☑	☑	☑

IHN-CCO members can find their dental plan assignment on their IHN-CCO Member ID card. The member may also call IHN customer service to determine or change their dental plan assignment.

A dentist is assigned to the member through each dental plan. If the member would like to change their dentist or office location, they need to contact their assigned dental plan to do so.

If you need assistance with coordinating care between your practice and a dental provider, please connect with your patient's dental plan. Samaritan's dental partners offer care coordination to assist with these requests. Patients do not need a prior approval to see their dentist for routine, emergent or urgent dental needs.

If a patient presents with emergent dental symptoms, e.g., severe tooth pain, a tooth that has been knocked out, severe swelling or infection of the gums around the tooth, or a serious abscess, please use appropriate judgment on referrals. The emergency department does not have the appropriate equipment or qualified professionals to appropriately diagnose and treat the cause of the symptoms. The dental plans have emergency protocols in place to accommodate outside of office operating hours emergency dental needs.

Organization	Contact phone
IHN-CCO	888-435-2396
Advantage Dental	866-268-9631
Capitol Dental Care	800-525-6800
ODS	800-342-0526
Willamette Dental Group	855-433-6825

Section 7: Quality improvement program

SHP's quality improvement (QI) program provides an overview of the structure and processes that enable the health plan to carry out its commitment to ongoing improvement in care and service and member health. The health plan's objective is to give members compassionate and effective care that is easily accessible, safe, equitable and affordable.

2025 QI program goals:

A. Deliver quality care and services that set community standards.
B. Give members care that is compassionate and effective.
C. Deliver cultural and linguistic care to all members and provide equitable access to care. Make equity part of practice, process, action, innovation and organizational performance.
D. Engage and align provider network to deliver care that promotes healthy outcomes via value-based care and other innovative payment and relationship models.

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

The QI program provides for review and evaluation of all aspects of health care, encompassing both clinical care and services provided to members. The scope of the quality review reflects the health care delivery systems, including quality of clinical care and services. All activities are designed to meet the individual needs of the member population in terms of age groups, disease categories, special needs and risk status, including those members with complex needs.

The scope of services includes services provided in institutional settings, such as acute inpatient, outpatient, long term care, skilled nursing, ambulatory care, home care, behavioral health and services provided by primary care, specialty care and other practitioners.

7.1 Quality Improvement workplan

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

The QI workplan:

A. Quarterly project implementation plans, data management and monitoring processes to achieve SHP quality and population health goals and meet regulatory requirements.
B. Identifies specific measurements for quality and population health program goals, objectives and compliance activities.
C. Includes key milestones, improvement targets and key performance indicators.

7.2 Quality Management Council

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

7.3 Quality improvement projects

The QI program includes numerous quality improvement projects. The Chronic Care Improvement Program for Medicare Advantage members ensures that members with chronic conditions are effectively managed. The performance improvement projects (PIPs) for IHN-CCO members focus on improving care and health outcomes. SHP encourages providers to review the list of current quality improvement projects.

7.4 Evidence-based clinical practice guidelines

SHP evaluates practice guidelines, standards and policies for dental care, medical and behavioral health practice to ensure alignment with evidence-based practice, community standards and relevant law. The UM committee reviews, adopts and disseminates evidence-based clinical practice guidelines.

Clinical practice guidelines (CPGs) are reviewed and updated at least every two years or as needed to reflect current standards and scientific knowledge. CPGs encompass acute, chronic and preventive care relevant to the SHP membership. CPGs are available to community clinicians, network providers and members. To evaluate delivery of services in accordance with approved guidelines, annual performance measurements are analyzed using claims data, lab data, and electronic health record data.

7.5 OHA CCO metrics

OHA uses outcome and quality measures to demonstrate performance among Coordinated Care Organizations to improve the quality of care, eliminate health disparities and reduce costs. Measures fall into one of two categories: CCO incentive measures, for which CCOs are eligible to receive payments based on their performance each year, and state quality measures, which OHA has agreed to report to CMS as part of Oregon’s 1115 Medicaid waiver. IHN-CCO maintains a dashboard of performance metrics to evaluate performance and engages network providers in quality improvement initiatives to improve performance.

7.6 HEDIS/HOS/CAHPS

Healthcare Effectiveness Data and Information Set (HEDIS) performance measures allow SHP to benchmark and compare performance with similar health plans across the nation. HEDIS measures focus on:

A. Prevention, screenings and medication use.
B. Care provided for numerous conditions across all body systems.
C. Member's access to various health care services.
D. Overuse or receipt of inappropriate care.
E. Health care utilization for services and procedures in different care settings.

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

The Health Outcomes Survey (HOS) measures the physical and mental well-being of Medicare members over time. It is administered annually to a random sample of SAHP members who receive the survey again at the end of a 2-year period. The two survey results are compared to determine if the care received is keeping the member as healthy as possible.

The HOS is comprised of several components including questions:

A. To evaluate members' physical and mental health.
B. To address important problems associated with poor physical and mental functioning such as urinary incontinence, lack of physical activity and fall risk.
C. Related to chronic conditions, activities of daily living and sociodemographic information.

HOS results from questions related to bladder control, physical activity and fall risk are used in the health plans' Medicare Star rating.

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

7.7 Medicare Stars Program

The Medicare Part C & D Star ratings were developed by CMS to help beneficiaries compare health plans and providers based on quality and performance and to reward top-performing health plans. Star ratings measure the performance of Medicare Advantage plans across several key dimensions related to care and services received by plan members. Star measures include HEDIS rates, CAHPS and HOS survey responses, health plan operations and pharmacy.

Both medical (Part C) and pharmacy (Part D) measures are included in the Star rating. Health plans are assigned a Star rating for each measure (one through five with five being the highest) as well as an overall summary Star rating. SHP's goal for Samaritan Advantage Health Plans is to continue to improve performance across SHP and the provider network and advance to a 5 Star rating. Select Star measures are included each year in provider value-based payments.

Section 8: Disputes, appeals and grievances

8.1 Provider disputes

Provider disputes are separate from appeals and are handled outside of the appeals process. A provider may dispute claims-related issues such as:

A. Plan benefits (e.g., coverage or benefit maximums).
B. Member eligibility.
C. Provider contract adherence.
D. Timely claims filing.
E. Reimbursement (e.g., DRG/APC/outliers, payment modifiers, or payment issues).
F. Coordination of benefits.
G. Coding issues (e.g., bundling edits, CES edits, or frequency edits).

A provider dispute does not include the following:

A. Initial utilization review for prior authorization.
B. Post-service authorization review or claim denials for lack of prior authorization.
C. Initial claim decision based on medical necessity or experimental and investigational coverage criteria.

Claim disputes from contracted providers should be submitted within 365 days of the claim remittance and do not require member consent. Please allow up to 60 days for the dispute to be reviewed. Non-contracted providers must follow the appeals process.

If you need to submit a dispute, please fill out the Provider Dispute form, attach all necessary documentation and fax or mail it to the appropriate address listed below by line of business.

Fax: 541-768-9356

Mail:

InterCommunity Health Network CCO
PO Box 887
Corvallis, OR 97339

Samaritan Employer Group PPO
PO Box 887
Corvallis, OR 97339

Samaritan Choice Plans
PO Box 336
Corvallis, OR 97339

Samaritan Advantage Health Plans
PO Box 1510
Corvallis, OR 97339

For questions, please contact SHP Provider Services at **541-768-5207** or toll free **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m.

8.2 Provider appeals

Appeals are separate from disputes. Providers may submit an appeal for the following:

A. Initial utilization review (prior authorization).
B. Post-service authorization review or claim denials for lack of prior authorization.
C. Initial claim decision based on medical necessity or experimental and investigational coverage criteria.

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

For further information about appeal rights, time frames to submit appeals and to download appeals forms for each plan, please visit the SHP appeals web page.

8.3 Samaritan Advantage Health Plans

Urgent pre-service denials

Medical appeal

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

Pharmacy appeal

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

Standard pre-service denials

Medical appeal

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

Medicare assumes the treating provider has documented a conversation with the patient regarding the intent to appeal on their behalf.

Pharmacy appeal

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

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

Payment denials

A contracted provider does not have appeal rights. If a contracted provider wants to appeal on the patient's behalf, they may do so only after completing an Appointment of Representative form, also referred to as a CMS 1696 form, a legal court appointed representative document or the equivalent. Both the patient or legal representative and the contracted provider must complete their applicable sections of the form before the appeal will be processed.

A. The member and the provider need to complete, print and sign the Medicare Appointment of Representative form, CMS 1696 form and include this with your appeal. Send the form, the appeal requests and any supporting documentation to SHP to the attention of the Appeal Team.
B. Any non-contracted provider can appeal a denied payment after completing a Waiver of Liability statement. Send the waiver and any supporting documentation to SHP to the attention of the Appeal Team.

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

Fax: 541-768-9765
Email: shpoappealsteam@samhealth.org
Mail: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

Timeframe to appeal

SAHP	Time frame to request appeal	Appeal time
Medical	60 days from the initial decision	Expedited = 72 hours Standard pre-service = 30 calendar days Standard post-service = 60 calendar days
Pharmacy and Part B	60 days from the initial decision	Expedited = 72 hours Standard = Seven calendar days, extension is prohibited
Extension, when applicable for processing a medical pre-service appeal.		Additional 14 calendar days (pre-service ONLY)

8.4 InterCommunity Health Network CCO

IHN-CCO, subcontractors and participating providers may not:

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

Urgent situations

A member or a member's authorized representative or provider can appeal a pre-service denial on their patient's behalf by submitting a verbal or written request directly to IHN-CCO **with** member's (or member's authorized representative) written consent.

To submit a verbal request, please call IHN-CCO Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST. Written requests can be emailed to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary.

This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

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

Standard pre-service and payment denials

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

For help with filing an appeal, please contact IHN-CCO Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST. Please submit your completed appeal letter with the member's (or member's authorized representative) written consent by one of the following:

Fax: 541-768-9765
Email: shpoappealsteam@samhealth.org
Mail: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

State fair hearing:

A hearing cannot be requested without first filing an appeal with IHN-CCO. A member or a member's authorized representative and/or provider may have access to appeal for IHN-CCO's action by requesting a contested case hearing with a written consent from the member's or member's authorized representative. The hearing can be requested through the Office of Administrative Hearings no later than 120 days from the date of the notice of appeal resolution. Expedited hearings should be submitted to OHA and can be requested verbally, in writing or online. The hearing request forms OHP 3302 or MSC 443 can be found on the OHA website.

Continuation of benefits pending appeal resolution:

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

A. The member withdrawals the appeal.
B. IHN-CCO issues an appeal resolution.
C. The original authorization expires, or the authorization service limits are met.

Continuation of benefits pending Contested Case Hearing resolution

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

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

Time frame to appeal

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

Grievances

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

To submit a grievance, please contact IHN-CCO Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST. You may also submit your grievance to IHN-CCO Grievance team at shpogrvcteam@samhealth.org or to Oregon Health Plan Client Services listed below.

A member or a member's authorized representative and/or provider may file a grievance directly with OHP and/or IHN-CCO on behalf of the member with the member's written consent. Please submit your grievance to: The Oregon Health Plan by mailing, calling or online:

Mail: Oregon Health Plan
Client Services
PO Box 14520
Salem, OR 97309
Phone: 800-273-0557 (OHP Client Services)
Online: apps.state.or.us/forms/served/he3001.pdf

Time frame for grievances

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

8.5 Samaritan Choice Plans

Urgent situations

Any provider can appeal, without written consent from the member, a pre-service denial on their patient's behalf by submitting a verbal or written request directly to Samaritan Choice Plans (SCP).

To submit a verbal request, please call SHP Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST. Written requests can be sent to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary. This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

Standard pre-service and payment denials

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

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

Fax: 541-768-9765
Email: shpoappealsteam@samhealth.org
Mail: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

Timeframe to appeal

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

8.6 Samaritan Employer Group Plans

Urgent situations

Any provider can appeal, without written consent from the member, a pre-service denial on their patient's behalf by submitting a verbal or written request directly to Employer Group Plans.

To submit a verbal request, without written consent from the member, please call SHP Provider Services at **541-768-5207** or **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST. Send written requests to shpoappealsteam@samhealth.org with a supporting statement as to why an expedited or urgent request is necessary.

This applies when the patient has not received the service and the provider believes that applying the standard appeal time frame could seriously jeopardize the patient's health, life or ability to regain maximum function or the patient's pain cannot be controlled by means other than by the denied service.

Standard pre-service and payment denials

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

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

Fax: 541-768-9765
Email: shpoappealsteam@samhealth.org
Mail: Samaritan Health Plans
Attn: Appeals team
PO Box 1310
Corvallis, OR 97339

Time frame to appeal

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

Section 9: Pharmacy

9.1 Formulary

SHP maintains a formulary or list of prescription medications that are approved for use or coverage by the plan and dispensed through participating pharmacies. Drug formularies are developed and maintained with direction from the SHP Pharmacy and Therapeutics Committee and specific to the member's insurance plan. SHP may modify the drug formulary to ensure that the formulary includes the most current evidence-based information.

SHP contracts with a pharmacy benefit manager for administration of the outpatient prescription benefit. This does not apply to injectable medications administered in an inpatient setting, for example, skilled nursing facilities, group homes or hospitals. Exceptions may apply for Samaritan Advantage Health Plans. Generic medications are encouraged when available except when the generic product is contraindicated. Prescriptions may be dispensed for the length of time specified in the chart below. Medications have a 75% utilization for most drugs; controlled substances have a 90% utilization at retail or 80% through mail-order required prior to refill.

Plan	Allowed dispensing amounts
Samaritan Advantage	Non-specialty: 90 days Specialty and drugs marked NDS on formulary: 30 days non-LTC; 31 days LTC **Controlled substances:** New to therapy: seven days (max 90 MME) Experienced: 30 days non-LTC (max 200 MME); 31 days LTC (max. 200 MME)
Commercial plans	Non-specialty: 90 days Specialty: 34 days **Controlled substances:** New to therapy: seven days (max 50 MME) Experienced: 30 days (max 90 MME) **Contraceptives:** Samaritan Choice Plan: one year Large and Small Group Plans: one year
InterCommunity Health Plan	34 days **Controlled substances:** New to therapy: seven days (max 50 MME) Experienced: 30 days (max 90 MME) *Certain formulary and generic oral maintenance medications to treat diabetes, hypertension, cholesterol and all contraceptives are allowed to be filled for 90 days.

Some prescriptions require pre-authorization (this may not apply when administered in an inpatient hospital or SNF setting). Most medications that require preauthorization have specific criteria and approval periods documented for providers to reference prior to submitting a request for coverage.

9.2 Non-formulary drugs

If it is medically necessary for a member to have a drug that is not on the member's insurance plan formulary, a formulary exception request may be submitted. For all plans, a provider may submit the **formulary exception** request via fax using the form available on the provider forms page or prescribers may submit a request electronically through either of SHP's electronic prior authorization partners:

A. SureScripts.
B. CoverMyMeds.

For Medicare plans, a provider, member or member's representative may submit a request for a medication exception by calling SHP Customer Service at **541-768-7866** or toll free **866-207-3182** (TTY **800-735-2900** or **711**), Monday through Friday, 8 a.m. to 8 p.m. PST.

9.3 Specialty drugs

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

Authorization requests for all outpatient provider-administered drugs, oral oncology medications and a limited number of self-administered specialty medications must be submitted through the Optum Specialty Fusion platform or by calling **800-385-3593**.

9.4 Quantity limits

For certain drugs, there are restrictions on the amount or quantity of medication that the plan will cover over a specific time period. These requirements are developed using FDA and manufacturer dosing guidelines, current evidence-based best practices and the latest pharmaceutical compendia. These limitations are reviewed and approved by the SHP P&T

Committee. Please consult the formularies on SHP's website for more information about these requirements and limits. For all plans, a provider may submit the formulary exception request via fax using the form available on the provider forms page or prescribers may submit a request electronically through either of these electronic prior authorization partners:

A. SureScripts.
B. CoverMyMeds.

For Medicare plans, a provider, member or member's representative may submit a request for a medication exception by calling SHP Customer Service at **541-768-7866** or toll free **866-207-3182** (TTY **800-735-2900** or **711**), Monday through Friday, 8 a.m. to 8 p.m. PST.

9.5 Step therapy

Step therapy is used for medications that are not first line treatment and require one or more prerequisite medications before prescribing. SHP enforces step therapy for medications as determined by the SHP P&T Committee. SHP requires the use of a less expensive medication when there is a cost difference between therapeutically equivalent medications. SHP approves the next step in therapy when members are unable to tolerate the first line medications or have adverse outcomes when taking the first line medications. The SHP claims system may automatically bypass step therapy criteria if it recognizes claims in the members history meeting the required criteria. When a claim is adjudicated, the claims payment system looks for any instance of a first line medication and if found, will automatically approve the claim. If, however, the first line medication is not found, the claims payment system denies the claim and gives a rejection notice to follow step therapy. For all plans, a provider may submit the formulary exception request via fax using the form available on the provider forms page or prescribers may submit a request electronically through either of these electronic prior authorization partners:

A. SureScripts.
B. CoverMyMeds.

For Medicare plans, a provider, member or member's representative may submit a request for a medication exception by calling SHP Customer Service at **541-768-7866** or toll free **866-207-3182** (TTY **800-735-2900** or **711**), Monday through Friday, 8 a.m. to 8 p.m. PST.

9.6 Tier lowering

Prescription costs can often be a barrier for many patients. If a patient’s drug cost is too high, perhaps there is a different drug in a lower cost sharing tier that might work just as well for the patient. Using the plan formularies, you can find alternatives that may be more cost effective for your patients. If there are no alternatives on a lower tier, you can ask the plan to make an exception to the cost sharing tier. If the request qualifies for a tier exception and is approved by

the plan, the patient may pay less for their medication. For all plans, a provider may submit the formulary exception request via fax using the form available on the provider forms page or prescribers may submit a request electronically through either of these electronic PA partners:

A. SureScripts.
B. CoverMyMeds.

For Medicare plans, a provider, member or member's representative may submit a request for a medication exception by calling SHP Customer Service at **541-768-7866** or toll free **866-207-3182** (TTY **800-735-2900** or **711**), Monday through Friday, 8 a.m. to 8 p.m. PST.

9.7 Electronic prior authorization

SHP has implemented electronic prior authorization services for SHP's providers with SureScripts and CoverMyMeds. This is a free service for those who have access through their integrated EHR, through their SureScripts provider portal or by creating an account through CoverMyMeds. Electronic prior authorization submission is designed to give clinicians and staff more time to focus on quality patient care without the administrative burden of manual prior authorizations. This saves users valuable time by eliminating the forms, faxes and phone calls associated with submitting prior authorizations. To sign up and get started, please visit:

A. SureScripts.
B. CoverMyMeds.

9.8 Adherence

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

9.9 Required Medicaid enrollment

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

9.10 Prescription Drug Monitoring Program

IHN-CCO and SHP expect prescribers of opioid medications, in accordance with the SUPPORT Act, to check the Prescription Drug Monitoring Program database prior to the prescribing of such medications.

All Oregon-licensed physicians and physician assistants who have a U. S. Drug Enforcement Agency (DEA) registration number are required to register for the Prescription Drug Monitoring Program (PDMP). For more information, please review OAR 847-010-0120 and OAR 333-023-0825.

For questions, contact the PDMP at **866-205-1222** or pdmp.health@state.or.us.

Attention: OHA adopted temporary rules to align with requirements in 42 U.S.C. 1396w-3a. The temporary rules require Oregon Health Plan's enrolled providers and Coordinated Care Organization's contracted providers to check the PDMP before prescribing controlled substances to covered individuals. See OAR 410-120-1260(20) and OAR 410-141-3855(15) for details.

Section 10: Providers

10.1 Eligible providers

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

Providers and practitioners

A. Doctor of medicine.
B. Doctor of osteopathy.
C. Oral surgeon, doctor of dental medicine.*
D. Podiatrist.

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

Allied and behavioral health care providers

A. Audiologist.
B. Behavior analyst, board certified.
C. Certified nurse midwife.
D. Certified registered nurse anesthetist.
E. Clinical nurse specialist.
F. Genetic counselor (when services are a covered benefit of the member's plan).
G. Hearing aid specialist.
H. Licensed clinical social worker.
I. Licensed dietitian.
J. Licensed marriage and family therapist.
K. Licensed professional counselor.
L. Nurse practitioner.
M. Occupational therapist.
N. Optometrist.
O. Pharmacist.
P. Physician assistant.
Q. Physical therapist.
R. Psychologist.
S. Psychologist associate.
T. Speech/language therapist.

Alternative care providers

A. Acupuncturist.
B. Chiropractor.
C. Licensed massage therapist.
D. Naturopath.

Organizational providers

A. Behavioral health facility.
B. Birthing center.
C. Clinical laboratory.
D. Comprehensive outpatient rehabilitation facility.
E. Durable medical equipment supplier.
F. End-stage renal disease dialysis center.
G. Federally qualified health center.
H. Freestanding ambulatory surgery center.
I. Home health agency.
J. Home infusion.
K. Hospice.
L. Hospital.
M. Independent diagnostic testing facility.
N. Portable X-ray supplier.
O. Public health center.
P. Rural health clinic.
Q. Skilled nursing facility.
R. Sleep study lab.

Credentialing exclusions

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

A. Anesthesiologists.
B. Behavioral health care practitioners.
C. Emergency room physicians.
D. Hospitalists.
E. Neonatologists.
F. Non-licensed providers (as required by state or federal statute).
G. Pathologists.
H. Radiologists.

Note: Anesthesiologists, behavioral health care practitioners, hospitalists, radiologists and others who occasionally work in the private clinic setting must complete the credentialing process.

10.2 Primary care providers

When a provider is designated as a primary care provider under the IHN-CCO or Samaritan Advantage Health Plans, they agree to provide and coordinate health care services for those

assigned panel of members. The PCP will refer members to in-network provider specialists and is also responsible for reviewing treatment rendered by specialists or other servicing providers.

10.3 Locum tenens

A locum tenens arrangement is made when a participating provider leaves their practice temporarily due to illness, vacation or leave of absence. Locum tenens is a temporary replacement for that provider, for a specified amount of time, not to exceed 60 days. Per NCQA standards, provisional credentialing is required for locum tenens providers who work 60 days or less. If the temporary replacement provider will be covering for more than 60 days, full credentialing is required.

10.4 Traditional health workers

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

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

Specialty types of THWs and the services they provide:

A. **Birth doula**: Provides support to members and their family during pregnancy, childbirth and after giving birth.
B. **Community health worker**: Helps members adopt healthy behaviors and navigate the health care system.
C. **Certified recovery mentor**: Focuses on supporting the member through recovery from addiction and have personal experience with addiction.
D. **Personal health navigator**: Provides information, assistance, tools and support to help members make the best health care decisions.
E. **Peer support specialist**: Focuses on supporting members through recovery from addiction and/or mental health conditions.
F. **Peer wellness specialist**: Works as part of the member-driven care team. This team combines behavioral health and primary care needs to assist and advocate for the member in improving their well-being.

Please contact SHP's traditional health worker liaison to learn more at **541-768-5207** or toll free **888-435-2396**, Monday through Friday, 8 a.m. to 8 p.m. PST.

10.5 Networks

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

Samaritan provider network

SHP's network covers Benton, Lincoln and Linn counties and many providers and facilities throughout the state of Oregon. Providers contracted with any SHP line of business can be found through a searchable directory.

First Choice Health Network

First Choice Health Network consists of primary care, specialty care and facilities throughout Alaska, Colorado, Idaho, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming. This network is accessible to Samaritan Choice Plans' and Samaritan Employer Group Plans' members.

First Health Network

First Health Network offers additional U.S. coverage outside of the First Choice Health Network. This network is accessible to Samaritan Choice Plans' and Samaritan Employer Group Plans' members.

The CHP Group

The CHP Group is a network of alternative and holistic care providers consisting of naturopathic care, chiropractic services, acupuncture treatments and massage therapy. SHP utilizes this network for services provided to Samaritan Employer Group Plans' members.

10.6 Contracting

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

If you are interested in contracting with one or more of SHP's lines of business, complete the Provider Request to Join Network form located on the SHP provider website.

By joining the Samaritan Health Plans network of providers, SHP will provide you with tools and resources to support you and collaborate to work effectively and efficiently, together. In-network providers can access and benefit from:

A. Direct support for all contracting, claims and operational inquiries.

B. Provider trainings and educational materials.
C. The provider manual, which includes policies and procedures.
D. Provider directories listing all contracted providers.
E. Quality programs and initiatives.

10.7 Credentialing

SHP's credentialing standards follow the guidelines of the National Committee on Quality Assurance, also known as NCQA, and CMS. The credentialing process includes meticulous verification of the education, experience, judgment, competence and licensure of all health care providers.

SHP believes the emphasis on credentialing further demonstrates a commitment to qualified health care physicians and providers performing services SHP members require. SHP requires all providers rendering services to be individually credentialed before they can be considered an in-network provider under the provider contract.

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

A. Anesthesiologists.
B. Behavioral health care practitioners.
C. Emergency room physicians.
D. Hospitalists.
E. Neonatologists.
F. Non-licensed providers (as required by state or federal statute).
G. Pathologists.
H. Radiologists.

Note: Anesthesiologists, behavioral health care practitioners, hospitalists, radiologists and others who occasionally work in the private clinic setting must complete the credentialing process.

Initial credentialing process

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

Phase 1: Application

Providers are required to submit the appropriate application and complete the credentialing process prior to being considered an in-network provider with SHP.

A. Individual practitioners must submit the most current OHA-approved version of the Oregon Practitioner Credentialing Application.
B. Organizational providers must complete the Organizational Provider Credentialing Application.
C. Unlicensed mental health practitioners and associates are required to submit a completed Medicaid Validation Application.

Please note that any new practitioners in your group will be considered out-of-network until the credentialing process has been completed and the provider has been approved by the Samaritan Health Services Credentialing Committee.

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

Provider credentialing

Contracting is contingent on credentialing approval. SHP follows CMS and NCQA requirements for credentialing providers. To credential practitioners and other health care professionals, SHP requires:

A. Oregon Practitioner Credentialing (or Recredentialing) Application – required.
B. Completed and signed attestation and release form – required.
C. Completed and signed Attachment A (mark N/A if not applicable, sign and date) – required.
D. Copy of current, unrestricted Oregon state license and/or registration – required.
E. Current, valid DEA certificate(s), if applicable.
F. Copy of current liability certificate showing coverage dates and limits – required.
G. List of all medical malpractice carriers for the past five years, including carrier name, address, policy number, limits and any claims history information.
H. Copy of board certificate(s) – preferred.
I. Copies of medical school diploma and/or completion certificates from medical training – preferred.
J. Copies of internship and residency completion certificates – preferred.
K. List of all work, professional and practice history activities since completion of postgraduate training.
L. Hospital privileges, if applicable.

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

Exceptions: Providers are not required to be credentialed by SHP if they practice solely in an inpatient setting and provide care to members only because the member is directed to the hospital or other inpatient setting.

Please review credentialing requirements on the SHP provider website.

Facility credentialing

Samaritan Health Plans conducts a formal and ongoing assessment of its organizational facility providers which include, but are not limited to, hospitals (including inpatient rehabilitation facilities), skilled nursing facilities, behavioral health treatment facilities, chemical dependency treatment facilities, comprehensive outpatient rehabilitation facilities, birthing centers, free standing ambulatory surgical centers, home health and hospice agencies, trauma facilities, clinical laboratories, diagnostic imaging services, durable medical equipment suppliers and providers of end stage renal disease services.

During the credentialing process, SHP confirms the organizational facility provider is in good standing with all state and federal regulatory agencies, and, when appropriate, verifies the facility has been reviewed and approved by an accrediting body. If the organizational facility provider has not been approved by an accrediting body, they must meet SHP's standards as defined in the SHP Provider Selection, Retention, and Termination Policy. Primary source verification of licensure is not required. However, the organization must provide a copy of the license and accreditation report, or the information must be verified through alternative sources (e.g. verification of accreditation status by searching a list of accredited organizations on the accrediting body's website, such as The Joint Commission site, or by verification of license status with the state licensing body). A CMS or state review may be substituted for non-accredited organizational providers unless an organization facility provider is in a rural area as defined by the U.S. Census Bureau.

The following list of information Samaritan Health Plans needs to credential facilities:

A. Organization Provider Credentialing Application – required.
B. W9 form – required.
C. Current, valid DEA certificate(s), if applicable.
D. Copy of Medicare and/or Medicaid certification, if applicable.
E. Copy of current, unrestricted state license, certification and/or registrations specifically required to operate as a healthcare provider – required.

F. Copy of your current liability certificate – required.
G. Copy of certification from an accredited agency or current CMS/state survey, including corrective action plans for identified deficiencies – required.
H. Appropriate policies regarding the use of restraints and/or seclusion.

Recredentialing is required at a minimum of every three years. During the recredentialing process, SHP will confirm that organizational facility providers continue to be in good standing with all state and federal regulatory agencies and, when applicable, are reviewed and approved by an accrediting body. SHP contracts provide notice to the provider of any changes in its Medicare approval, Medicaid approval, state licensure or accreditation status.

For more information, contact Samaritan Health Plans' Provider Relations at **541-768-5207** or toll free **888-435-2396**, Monday through Friday, from 8 a.m. to 8 p.m. PST or at shpprovider@samhealth.org.

Phase 2: Review

The SHS Credentialing department is responsible for processing credentialing requests for providers requesting to participate in SHP's provider network. The SHS Credentialing Committee evaluates provider candidates for credentialing and makes the final determination. Credentialing criteria is based on standards set by NCQA and the credentialing committee is responsible for applying those criteria in a fair and impartial manner.

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

Phase 3: Decision

Upon the credentialing committee's approval, the provider is notified in writing of their acceptance. The provider will then be recredentialed at least every thirty-six (36) months. Providers who are not approved or do not meet the criteria set forth by the credentialing committee will be notified in writing via certified mail.

Effective Jan. 1, 2023, covered services will be reimbursed for dates of service during the credentialing period at the in-network benefit and under the terms of the provider's contract. Services must be billed after credentialing is approved. Claims submitted without approved credentialing will be denied and require resubmission after approval. Eligibility for reimbursement will begin on the date the completed credentialing application is received by the Credentialing Department or the effective date of the provider's contract with SHP, whichever is later.

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

Adequate professional liability coverage

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

Recredentialing

The recredentialing process will be conducted for each in-network provider no less frequently than every thirty-six (36) months, or according to applicable standards at the time. A notice that recredentialing is due will be sent to the provider approximately four to six months prior to the credentialing period expiration date.

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

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

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

Practitioner rights

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

A. The right to review information submitted to support the credentialing application, including information received from outside sources such as malpractice insurance carriers

and state licensing boards. This right does not include the ability to review references, recommendations, or other peer-review protected information.

B. The right to correct erroneous information when information submitted on the application varies substantially from information obtained during the credentialing process. The SHS Credentialing department will notify the provider when such information is identified, with the appropriate time frames and format to make necessary corrections. SHS is not required to reveal the source of the information verified, if federal or state law prohibits disclosure.
C. The right to be informed of the status of the credentialing and recredentialing applications, upon reasonable request. The Credentialing Department may provide projected timelines for completion, including possible delays, information pending or missing, and substantial variations in formation verified during the credentialing process.

10.8 Update your information

Demographic information

For members to have the most accurate contact information in the provider directories, SHP requires that providers submit all demographic changes to SHP within 30 days.

Adding or terminating a provider

If you are an established contracted group, complete the Update Your Information form online to begin the process of adding or terminating a provider from your group. Credentialing of a new provider can take up to 90 days so timely notification is essential.

10.9 Accessibility

Access to care

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

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

Travel times and distances

A. In urban areas: 30 miles or 30 minutes.
B. In rural areas: 60 miles or 60 minutes.

Physical health

A. Emergency care: immediately or referred to an emergency department depending on the

member's condition.
B. Urgent care: within 72 hours.
C. Well care: within four weeks or as otherwise required by applicable care coordination rules.
D. Members requesting history and physical, preventive exams and new patient exams are scheduled within 42 calendar days of the request.
E. Members with non-urgent care (symptomatic), including walk-ins and telephone calls, are seen within seven calendar days of request.

Oral and dental care for children and non-pregnant individuals

A. Dental emergency services as defined in OAR 410-120-0000: Seen or treated within 24 hours.
B. Urgent dental care: within two weeks.
C. Routine oral care: within eight weeks, unless there is a documented special clinical reason that makes a period of longer than eight weeks appropriate.

Oral and dental care for pregnant individuals

A. Dental emergency services: Seen or treated within 24 hours.
B. Urgent dental care: within one week.
C. Routine oral care: Within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate.

Behavioral health

A. Urgent behavioral health care for all populations: within 24 hours.
B. Routine behavioral health care for non-priority populations: assessment within seven days of the request, with a second appointment occurring as clinically appropriate.

Specialty behavioral health care for priority populations

A. If a time-frame cannot be met due to lack of capacity, the member must be placed on a wait-list and provided interim services within 72 hours of being put on a wait-list.
B. Pregnant women, veterans and their 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 individuals within the intellectual and developmental disability populations: 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 wait-list.
C. 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 services are necessary due to capacity restrictions, admission must commence within 120 days from placement on a wait-list.
D. Opioid use disorder: Assessment and entry within 72 hours.

E. Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry.
F. Children with serious emotional disturbance as defined in OAR 410-141-3500.

Note: 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.

On-call policy

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

Hours of operation

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

Limiting or closing a practice

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

A. Closed as a PCP, open as a specialist.
B. Age limitations.
C. Not accepting new members.

To be compliant with the No Surprises Act, OHA and CMS Medicare rules, SHP requires all contracted providers to attest every 90 days that their information in the provider directory is correct. Failure to attest limits SHP's ability to ensure members have access to your most up-to-date information regarding you and your practice and may result in your information being removed from the health plan's online provider directories.

Written notifications must be received prior to any changes taking place. This will ensure the provider directory will display the most up-to-date information for SHP's members. Visit SHP's provider website to update your panel availability.

For questions or to email a notification, contact SHP Provider Relations at **541-768-5207**, toll free at **888-435-2396**, Monday through Friday, 8 a.m. to 8 p.m. PST or at shpprovider@samhealth.org.

Language interpretation requirements

Oregon House Bill 2359 relating to health care interpreters was established to ensure compliance with the following federal and state laws:

A. Title VI of the Civil Rights Act of 1964.
B. Section 1557 of the Affordable Care Act.
C. Code of Federal Regulation (CFR) at 45 CFR Part 92.

Oregon Revised Statute (ORS) 413.552 found that equitable communication services are essential to improving health outcomes and enhancing the patient-provider relationship for people with limited English proficiency, also known as LEP, or who are deaf and hard of hearing.

Providers are responsible for ensuring that their practice or clinic offers timely and free interpretation services to all members with LEP or those who communicate primarily using sign language. Members who may be considered LEP are individuals who do not speak English as their primary language and/or have a limited ability to read, speak, hear, write or understand English. Providers and provider clinics that receive federal funding, including Medicare and Medicaid reimbursement dollars, are required to provide these services.

ORS 413.550 to 413.559 outlines the following:

A. Health care providers must work with a health care interpreter, also known as a HCI, from the health care interpreter registry produced by OHA under ORS 413.558 when communicating with a patient who prefers a language other than English.
B. A certified HCI must abide by the testing, qualification and certifications of HCI listed in ORS 413.558.
C. ORS 413.559 requires the following data be collected by the provider for each interpreter service encounter:
    1. The name of the health care interpreter.
    2. The health care interpreter's registry number.
    3. The language interpreted.

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

IHN-CCO language access

Qualified or certified health care interpreter services

All providers contracted with IHN-CCO must make interpreting services available to IHN-CCO members. Services must be available during and after hours for consultation and provision of care. While interpreter services can be acquired with short notice, please schedule as soon as a member makes an appointment to ensure coverage.

Interpreter services must be performed by **certified** or **qualified** health care interpreters and can be part of the providers staff or scheduled through a Samaritan preferred vendor (listed below).

A. **Certified interpreter**: highest level of medical interpreter training. Certified interpreters are certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. This includes passing a standardized national test.
B. **Qualified interpreter**: assessed and demonstrates a high level of proficiency in at least two languages. Qualified interpreters have the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care. A qualified interpreter will have:
    1. A high school diploma.
    2. 60 hours of interpreter training approved by the Oregon Health Authority.
    3. Proof of language proficiency in English and target language.
    4. Their name listed on the OHA's HCI Registry.

Providers or staff who are bilingual or have some degree of proficiency in more than one language are **not** qualified to serve as an interpreter without the criteria defined above and are **not** eligible for reimbursement. Providers are discouraged from using bilingual family members for interpretation.

Certified or qualified providers and staff

Providers and staff who are certified or qualified health care interpreters can be reimbursed when their interpreter services are used during a covered, medically necessary service (including telehealth).

Providers should bill interpreter services using code T1013. Claims must be submitted by the provider rendering the office visit as the interpreter is unable to enroll and bill as a Medicaid provider. Providers should bill both the office visit and the interpreter service on the same claim form. Reimbursement will be based on the terms of the provider's contract with IHN-CCO. The fee cannot be billed in conjunction with bundled rate services that incorporate administrative costs (e.g., inpatient hospital stays, home health or hospice visits, services provided by long term care facilities or services billed at an encounter rate by rural health clinics, federally-qualified health

centers and tribal health centers).

Preferred interpreter service vendors

Samaritan has contracted with the approved vendors listed below to eliminate language barriers to accessing covered health care services and benefits. Please use this vendor list when serving IHN-CCO members.

Note: IHN-CCO only pays for interpreter services that providers coordinate through approved IHN-CCO vendors. Should a provider use a vendor other than an IHN-CCO-approved vendor, the provider will be responsible for coordinating and paying the interpreter service. If you use a vendor not listed below, let your Provider Relations representative know by emailing shpprovider@samhealth.org.

Linguava Interpreters

A. Service area includes Benton, Clackamas, Clatsop, Columbia, Jackson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, and Washington counties in Oregon.
B. American Sign Language.
C. All spoken languages.
D. **Modalities**: scheduled and on-demand video services for ASL and spoken languages; phone for spoken languages.
E. **Phone**: **800-716-1777**.
F. Webpage: linguava.com.

Oregon Certified Interpreters Network, Inc.

A. Services are offered for IHN-CCO members anywhere.
B. All spoken languages.
C. **Modalities**: scheduled and on-demand; on-site, video and phone.
D. **Phone**: **503-213-3191**.
E. **Webpage**: oregoncertified.com.
F. **Email**: scheduler@oregoncertified.com.

Passport to Languages

A. Services offered for IHN-CCO members anywhere.
B. American Sign Language.
C. **Modalities**: scheduled; on-site, video and phone.
D. No access code required for this vendor. The caller should state that they are calling on behalf of an IHN-CCO member and provide the member's name, date of birth and member ID.
E. **Phone**: **800-297-2707**.
F. **Webpage**: PassportToLanguages.com.

Required reporting

IHN-CCO requests that the following data be reported through Provider Connect for any IHN-CCO member who utilizes interpreter services:

A. Member's first and last name.
B. Member ID number.
C. Date of service.
D. Visit type/care setting.
E. Type of interpretation provided (i.e., telephonic, in person, video remote).
F. If the interpreter is OHA certified.
G. Interpreter's OHA registry number.
H. Whether the interpreter was a bilingual office staff person.
I. If the member refused interpretation services and the reason for member refusal.

The Provider Collaborative conducted by IHN-CCO staff provides an overview of the interpreter services regulatory requirements, the new Health Equity CCO metric and how to accomplish the interpreter service data collection requirements using the provider portal.

Non-emergent medical transport

IHN-CCO and Samaritan Advantage members are eligible for free transportation to and from covered medical services, 24 hours per day, 365 days per year, with Cascades West Ride Line (i.e., Ride Line).

To schedule a ride, the member must:

A. Call **541-924-8738** (TTY **711**) or toll free **866-724-2975** Monday through Friday, from 8 a.m. to 5 p.m. PST. Members may call Ride Line after hours or on holidays for urgent matters.
B. Schedule rides in advance to ensure availability.
C. If plans change, call to cancel their ride.

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

If the member needs assistance with scheduling a ride, please feel free to coordinate the phone call or allow the member to utilize a clinic phone when they do not have their own means of phone communication. Ride Line will need the following information to schedule the trip:

A. Member's first and last name, date of birth and home address.

B. Date and time of the appointment.
C. Address and phone number of the facility and health care provider name, if applicable.
D. Reason and duration of appointment.
E. Any special mobility needs.

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

10.10 Provider and member relationship

Dismissing IHN-CCO members

IHN-CCO members are required to be assigned to a primary care provider, and procedures are in place to ensure members continuously have access to a PCP. Please follow these guidelines:

A. Providers are required to notify IHN-CCO when a member misses any primary care appointment with no effort from the member to reschedule within 30 days.
    1. Scheduled and missed appointments should be documented in the member's file with the PCP.
    2. Any letter regarding a missed appointment that is sent to the member by the PCP should also be faxed to IHN-CCO at **541-768-9395** for documentation purposes.
B. If the member **continues** to miss appointments with no effort from the member to reschedule within 30 days. The provider may choose to dismiss the member only when the provider has previously notified IHN-CCO's Customer Service Department of no less than three missed appointments without rescheduling attempts. The letter of dismissal must be directed to the Customer Service Department and faxed to IHN-CCO at **541-768-9395**. The letter should explain the following, as applicable:
    1. The member's name and another identifier, typically DOB or member ID number.
    2. Whether the member is a new or established patient.
    3. The dates of all missed appointments.
    4. The specific reason for the dismissal, including behavioral reasons.
    5. Explanation that the member will receive emergency care only during the 30 days following the dismissal from the provider.
    6. Whether the dismissal is from the provider or from the entire clinic.
    7. Instructions for the member to contact IHN-CCO to arrange to choose a new PCP.

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

In most cases, a 30-day notice of dismissal will be considered reasonable. When the basis for dismissing a member from your practice is for disruptive behavior and the member is dangerous to other patients or staff, the period may be shortened to as little as one day. This is dependent

upon the seriousness of the threat and on IHN-CCO's ability to either terminate the member from the plan or to locate another network provider willing to accept the member within the range of one to 30 days. This also takes into consideration both the severity of the patient's condition and the availability of other care in the community within the period selected. Providers must inform IHN-CCO in writing of a member's uncooperative or disruptive behavior, describe the behavior and allow time for appropriate resolution prior to any refusal to provide services. This notification must be documented by the provider in the member's medical record.

A letter of dismissal must be directed to our Customer Service Department and faxed to IHN-CCO at **541-768-9395**. The letter should explain, as appropriate, the same information detailed above. Please notify SHP Customer Service of the dismissal at the same time you notify the patient.

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

A. Having a physical or mental disability.
B. Adverse change(s) in member's health.
C. Excessive or lack of utilization of services.
D. Diagnosis of end stage renal disease.
E. The member exercising their option to make decisions regarding their medical care with which the provider disagrees.
F. Exhibiting disruptive or uncooperative behavior because of the member's special needs.

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

Open communication

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

10.11 Culturally competent services

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

SHP expects providers to understand the importance of cultural differences and will provide care

to members without discrimination.

10.12 Advance directive and declaration of mental health treatment

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

Advance directive

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

Declaration of mental health treatment

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

10.13 Required provider education

SHP offers informational resources and requires educational training content to meet CMS requirements for Special Needs Plan Model of Care and Medicare FDR training.

Special Needs Plan Model of Care

Samaritan Health Plans operates a Medicare Dual Advantage plan for the dual-eligible population residing in Benton, Lincoln and Linn counties of Oregon. SHP also operates a Medicaid managed care plan for the region, IHN-CCO. SHP ensures that all physicians and providers permitted to practice independently under state law are properly credentialed per CMS, the Oregon Medicaid Program and SHP policies prior to providing health care services to Samaritan's Dual Advantage members.

The Special Needs Plan Model of Care, also known as SNP-MOC, annual training is offered to meet

the CMS regulatory requirements for MOC Training for Samaritan SNP-MOC providers. This training also ensures all contracted network providers and out-of-network providers who regularly see Samaritan Dual Advantage members have the specialized training this unique population requires. This includes all primary care providers and family practice providers that see Dual Advantage members, as well as any specialists that see these members as their primary care provider.

The SNP-MOC training must be completed, and an attestation submitted to SHP every three years.

Medicare FDR training

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

SHP offers informational resources about Medicare Compliance Program requirements, including required trainings and attestation.

10.14 Behavioral health directed payments

As of January 2023, the Oregon Health Authority has implemented four behavioral health directed payments within IHN-CCO contracts that will further the goals and priorities of the Medicaid program as follows:

A. Tiered uniform rate increase directed payment.
B. Co-occurring disorder directed payment.
C. Culturally and linguistically specific service directed payment.
D. Minimum fee schedule directed payment.

For additional information on each behavioral health directed payments type and answers to frequently asked questions, please visit SHP's behavioral health resources web page.

10.15 Required reporting for ROADS

Behavioral health providers offering services to IHN-CCO members are required to regularly report data to the state of Oregon. The Resilience Outcomes Analysis and Data Submission (ROADS) system facilitates data collection for all Oregon agencies that are required to participate. Launched on Mar. 11, 2025, the ROADS system replaced the former MOTS system. The ROADS system features:

A. Online data submission to replace submissions via emails and spreadsheets.
B. Flexibility for OHA to adjust data collection requirements and features without highly technical resources or outsourcing.
C. Advanced reporting capabilities that allow users to customize reports for their specific administrative needs.

For additional questions regarding MOTS or the ROADS project, please contact: roads@odhsoha.oregon.gov.

In addition, providers and their staff are encouraged to register for a ROADS webinar facilitated by OHA on a monthly basis. Further information about the ROADS system and required reporting, please visit OHA's ROADS webpage.

10.16 Medicare Annual Wellness Visit

SHP covers a Medicare Annual Wellness Visit (AWV) that delivers personalized prevention plan services for Medicare patients who:

A. Are **not** within 12 months after the patient's first Part B benefits eligibility date.
B. Did **not** get a Welcome to Medicare or AWV within the calendar year.
C. SHP pays AWV costs when the provider accepts assignment.

What services are covered during an initial AWV?

A. Perform health risk assessment.
B. Establish the patient's medical and family history.
C. Establish current providers and suppliers list.
D. Measure height, weight and body mass index (and other routine measurements deemed appropriate based on medical and family history).
E. Detect any cognitive impairment patients may have.
F. Review the patient's potential depression risk factors.
G. Review the patient's functional ability and level of safety.
H. Establish an appropriate patient-written screening schedule, like a checklist for the next five to 10 years.
I. Establish the patient's list of risk factors and conditions.
J. Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs.
K. Review current opioid prescriptions.
L. Screen for potential substance use disorders.

What services are covered during a subsequent AWV?

A. Review and update health risk assessment.

B. Update the patient's medical and family history.
C. Update current providers and suppliers list.
D. Measure height, weight and body mass index (and other routine measurements deemed appropriate based on medical and family history).
E. Detect any cognitive impairment patients may have.
F. Update the patient's written screening schedule.
G. Update the patient's list of risk factors and conditions where you recommend primary, secondary or tertiary interventions, or report whether they're underway.
H. As necessary, provide and update patient's personalized prevention plan services, including personalized health advice and appropriate referrals to health education or preventive counseling services or programs.
I. Review current opioid prescriptions.
J. Screen for potential substance use disorders.

Is the AWV the same as an annual physical exam?

The AWV is not an annual physical exam. The AWV is a comprehensive exam, which focuses on preventive care by establishing a personalized preventive plan.

Is the AWV the same as the Welcome to Medicare exam?

Both exams are similar in benefits; however, the Welcome to Medicare is only available to those members who are within their first 12 months of being Medicare eligible.

AWV billing and coding

You can only bill G0438 or G0439 once in a calendar year. G0438 is for the first AWV and G0439 is for subsequent AWVs.

A. G0438 — AWV; includes a personalized prevention plan of service and initial visit.
B. G0439 — AWV, includes a personalized prevention plan of service and subsequent visit.
C. G0468* — Federally qualified health center visit, initial preventive physical examination or AWV; a federally qualified health center visit that includes an initial preventive physical examination or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem, to a patient receiving an initial preventive physical examination or AWV.

*Section 60.2 of the Medicare Claims Processing Manual, Chapter 9 has more information on how to bill HCPCS code G0468.

Who can provide an AWV?

A. A physician who is a doctor of medicine (MD) or osteopathy (DO).
B. A physician assistant, nurse practitioner or clinical nurse specialist.
C. A medical professional (including a health educator, registered dietitian, nutrition

professional or another licensed practitioner).

What is the patient's cost share for an AWV?

There is no cost for this visit. However, a copay may apply for any additional services and/or testing. Please have your patient refer to their Samaritan Advantage Plan Evidence of Coverage or contact Customer Service to verify coverage.

10.17 Electronic Visit Verification

Section 12006(a) of the 21st Century Cures Act mandates that states implement Electronic Visit Verification (EVV) for all Medicaid personal care services and home health services that require an in-home visit by a provider. EVV is a Federally mandated requirement for all home health agencies to use an electronic tracking system for time spent with a client. The Oregon Health Authority has chosen the "Provider Choice Model" which allows providers to select their EVV vendor of choice and self-fund EVV implementation. To be compliant, home health agencies must report using the approved Electronic Visit Verification template located on OHA's policy page.

Section 11: Members

11.1 Member rights and responsibilities

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

Samaritan Advantage Health Plans (HMO) (Medicare)

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

Their rights as a member

A. They have a right to receive information in a way that works for them and is consistent with their cultural sensitivities (e.g., in languages other than English, in Braille, in large print or other alternate formats).
B. They have a right to timely access to their covered services and drugs.
C. They have a right to privacy and protection of their personal health information.
D. They have a right to information about their health plan, its network of providers and their covered services.
E. They have a right to know their treatment options and participate in decisions about their health care (e.g., choices, risks and the right to say “no”).
F. They have a right to give instructions about what is to be done if they are not able to make medical decisions for themselves.
G. They have a right to make complaints and to ask SAHP to reconsider decisions it has made.

Their responsibilities as a member

A. Become familiar with their covered services and the rules they must follow to get these covered services.
B. Notify SAHP when they have any other health insurance coverage or prescription drug coverage in addition to this plan.
C. Tell their doctor and other health care providers that they are enrolled in a Samaritan Advantage plan.
D. Help their doctors and other providers by giving them information, asking questions and following through on their care.

E. Be considerate.
F. Pay what they owe.
G. Tell SAHP if they move.
H. Call SHP Customer Service for help with questions or concerns at **541-768-7866** or toll free **866-207-3182** (TTY **800-735-2900** or **711**).

IHN-CCO (Medicaid)

Their rights are the things they can count on getting from IHN-CCO. Their responsibilities are the things IHN-CCO needs from them. As a person with IHN-CCO coverage, they have many rights and responsibilities.

Their rights as a member

Nondiscrimination

A. Be treated with dignity, respect and consideration for their privacy.
B. Be treated by their providers the same as others seeking health care.
C. Get handbooks and letters that they can understand.
D. Get services and support that fit their culture and language needs including auxiliary aids and services.
E. Have the same access to care as all members, no matter their age or sex.
F. Complain or appeal and get a response from IHN-CCO without a bad reaction from their plan or provider.
G. Be free from getting restrained or confined, unless allowable or needed.
H. Get a copy of IHN-CCO's nondiscrimination policy.
I. Exercise their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A and their right to report a complaint of discrimination by contacting IHN-CCO, OHA, the Bureau of Labor and Industries or the Office of Civil Rights.

Access

A. Choose an in-network primary care provider when they first enroll and change their PCP at other times.
B. Learn about CCOs and the health care system.
C. Get behavioral health and family planning services without a referral or prior approval.
D. Ask for services provided within a 30-mile radius if their home is in a city or 60 miles of their home if located outside a city. Services can be provided in a nontraditional setting that is easier for them to use.
E. Self-refer for a sexual abuse exam, if needed, without prior approval.
F. Get emergency care when they need it, any time of day or night (including weekends and holidays), with no prior approval required.
    1. Get emergency medical care as soon as possible.
    2. Get urgent care within 72 hours (three days).

3. Get well-care (preventive care) within four weeks or as required by care coordination rules.
4. Get emergency dental care within 24 hours.
5. Get urgent behavioral health care within 24 hours.

G. See some specialists without a referral.
H. For pregnant members, get care in the following timeframes:
   1. Get emergency dental care within 24 hours.
   2. Get urgent dental care within one or two weeks, as needed.
I. Get a referral to specialists for covered services that are needed based on their health.
J. See some specialists without a referral.
K. Get help using the health care system and get the resources they need. This could include:
   1. Certified or qualified health care interpreters.
   2. Certified traditional health workers.
   3. Peer wellness specialists.
   4. Doulas.
   5. Personal health navigators.
L. Get some health services on their own if they are younger than 18. OHP has a booklet called "Understanding Minor Consent and Confidentiality in Health Care in Oregon." This booklet tells them the types of services minors can get on their own. It also tells them how minors' health care information may be shared.
M. Choose to share information with IHN-CCO electronically.

Care

A. Get a ride to covered services at no cost.
B. Actively help develop their treatment plan or have family involved in their treatment plan.
C. Get information about OHP-covered and non-covered treatment options for their condition.
D. Agree to or refuse treatment (except for court-ordered services) and be told how that treatment will affect them.
E. Get the tests they need to find out what condition they have.
F. Get coordinated care and services that are specific to their needs and are medically needed.
G. Get care in a language and culture that aims to reduce the need for hospital or nursing home visits.
H. Have steady and stable contact with a care team that oversees their complete care management.
I. Get covered services that help them stay healthy.
J. Have a medical chart kept up to date by their doctor.
K. See and get a copy of their medical chart unless there is a legal reason that does not allow it. They may ask to change or correct what is in their chart.
L. Have their medical chart sent to another provider.
M. Have an advance directive or power of attorney and have their providers follow it.
N. Get a letter if they are denied a service or if there is a change in service. They may not get a

letter if the law does not require it.

O. Be told ahead of time if their appointment is not going to happen.
P. Get covered services without owing copays.
Q. Get a second opinion from a provider in the IHN-CCO provider network. If they need a doctor outside the IHN-CCO network, IHN-CCO can help them find one. They can get a second opinion at no cost to them.
R. Get their provider's opinion on treatment available to them.
S. Get extra dental health care if they become pregnant.
T. Let their PCP know within three days (72 hours) if they used emergency services.

Support

A. Have a friend, family member or helper come to their appointments.
B. Have a helper that will coordinate their care in the best location for them.
C. Ask IHN-CCO how to connect to people who can support their overall health and well-being.
D. Ask for a hearing with the state if they do not agree with IHN-CCO's appeal answer.
E. Get an interpreter approved by the state, at no cost to them.
F. Get person-centered care and services that give them choice, independence and dignity.
G. Exercise their member rights without any negative effects.
H. Get care coordination, community-based care and help with care transition in a way that works with their language and culture to reduce the need for hospital or nursing facility visits.
I. Share their concerns with the OHP ombudsperson. They can help advocate for them.

When members applied for OHP, they agreed to give true and correct information. The below section tells them more about additional things they need to do as an IHN-CCO member.

Their responsibilities as a member

A. Work with their care team.
B. Find a doctor or other provider they can work with and tell them about their health.
C. Treat providers and their staff with the same respect they want.
D. Be on time for appointments.
E. Call their provider at least one day before their appointment if you cannot make it.
F. Have yearly check-ups, wellness visits and other services to stay healthy.
G. Go to their PCP for all their health care needs unless it is an emergency.
H. Contact their provider before going to urgent care or the emergency department unless their condition is life threatening.
I. Be honest with their provider so their medical record is correct.
J. Help their provider get medical records from other providers. They may need to sign a paper to give approval.
K. Ask questions when they do not understand.
L. Use their medical care team resources to make informed choices about your care.

M. Help their provider create a care plan.
N. Follow the treatment plan they agreed to with their medical care team.
O. Tell their provider they have IHN-CCO and show them their ID card if the provider asks.
P. Pay for services they agree to get that are not covered by IHN-CCO.
Q. Use urgent and emergency care appropriately.
R. Get a referral from their PCP to see a specialist if they need it. There are some cases when they do not need a referral.
S. Call OHP Client Services at **800-699-9075** when they or a family member move in or out of their house or change their phone number. Also, tell OHP Client Services when they become pregnant, are no longer pregnant or have a baby.
T. Inform Call OHP Client Services at **800-699-9075** to report any other health insurance. They can also report other health insurance at reporttpl.org.
U. Provide IHN-CCO facts about other sources who are paying for their care. Pay back IHN-CCO for any bills IHN-CCO paid if they get a medical settlement.
V. Tell IHN-CCO if they have a grievance.

Samaritan Choice Plans

Their rights as a member

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

Their responsibilities as a member

A. They are responsible for providing SCP and SCP providers with the information needed to care for them.
B. They are responsible for following treatment plans or instructions agreed on by them and their health care providers.
C. They are responsible for payment of copays at the time of service.

D. They are responsible for reading and understanding all materials about their health plan benefits and for making sure that family members covered under this plan also understand them.
E. They are responsible for making sure services are prior authorized when required by this plan before receiving medical care.
F. They are responsible for understanding their health problems and participating in developing mutually agreed upon treatment goals to the degree possible.

Samaritan Employer Group Plans

Their rights as a member

A. They have a right to be cared for by people who respect their privacy and dignity.
B. They have a right to be informed about Samaritan Health Plans, our providers, and the benefits and services they have available to them as a member.
C. They have a right to receive information that helps them select a qualified practitioner whom they trust and with whom they feel comfortable.
D. They have a right to candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
E. They have a right to receive information and clinical guidelines from their health care provider or SHP that will enable them to make thoughtful decisions about their health care.
F. They have a right to actively participate in decisions that relate to their health and their medical care through discussions with their health care provider or through written advance directives.
G. They have a right to have access to medical services that are appropriate for their needs.
H. They have a right to express a concern or appeal and receive a timely response from SHP.
I. They have a right to have their claims paid accurately and promptly.
J. They have a right to request a review of any service not approved, and to receive prompt information regarding the outcome.
K. They have a right to be informed about and make recommendations regarding SHP member rights and responsibilities policy.
L. They have a right to refuse care from specific providers.

Their responsibilities as a member

A. They are responsible for talking openly with their physician or provider, understanding their health problem and working toward a relationship built on mutual trust and cooperation.
B. They are responsible for developing mutually agreed-upon treatment goals with their qualified practitioner, to the degree possible, and following treatment plans and instructions.
C. They are responsible for supplying, to the extent possible, information that SHP and their physicians need to provide care.

D. They are responsible for doing their part to prevent disease and injury and trying to make positive and healthful choices. If they do become ill or injured, they are responsible for seeking appropriate medical care promptly.
E. They are responsible for treating their physicians or providers with courtesy.
F. They are responsible for making their required copayment at the time of service.
G. They are responsible for showing their member ID care whenever they receive medical services.
H. They are responsible for letting SHP know if they have concerns or if they feel that any of their rights are being compromised, so SHP can act on their behalf.
I. They are responsible for calling or writing within 180 days of date of service if they wish to request a review of services provided or appeal a SHP decision.
J. They are responsible for notifying SHP Customer Service if their address changes.

11.2 Second opinions

IHN-CCO provides members with opportunities to seek a second opinion from a qualified health care provider within the network or arranges for a second opinion outside of the network, at no cost to the member.

Section 12: Risk adjustment

12.1 Medical records standards

Documentation within the medical record reflects the type of care delivered. Medical records must contain all the information necessary to support claims for provider services. Accreditation and regulatory agencies may also review patient records as part of their oversight.

For each visit, the following information must be documented to code the encounter appropriately (if applicable):

A. Date and time of entry, with author and their credentials identified.
B. Reason for patient visit.
C. Patient history and health behaviors, to include the following:
    1. Tobacco habits, including advice to quit.
    2. Alcohol or other substance use (ages 11 and over).
    3. Immunization records.
    4. Preventive screenings and services, including dates and results.
    5. Risk screenings.
    6. Screening for depression and evidence of coordination with behavioral health care providers as indicated.
    7. Blood pressure, height, weight and body mass index.
    8. Physical assessment for each visit.
    9. Growth charts for children and developmental assessments.
    10. Physical activity and nutritional counseling.
D. Unresolved problems from previous visits.
E. Documentation and review of any recent hospitalizations, including reconciliation of current medications with discharge medications.
F. Problem list with medical history, chronic conditions, significant illnesses, surgeries and accidents.
G. Documentation of chronic conditions that affect patient care that were monitored, evaluated, assessed or treated for each visit.
H. All services that were provided, including ancillary services, tests ordered, and diagnostic or therapeutic services referred by the care provider.
I. Diagnosis, patient status and treatment plan.
J. Review of any consultations, labs, imaging, special studies or ancillary records initialed by PCP.
K. List of all current medications, medication reviews and medication changes, including dosages and over-the-counter medications.
L. Allergies and adverse reactions. If no known allergies, this must also be documented.
M. Follow-up plan of care.
N. All patient education, counseling or coordination of care provided.
O. Provider signature.

Unless otherwise stated in your agreement, providers are required, at no cost to Samaritan Health Plans, to:

A. Provide electronic copies of SHP members' medical records for all dates of service or provide access to medical records 24 hours per day, 7 days per week.
B. Supply records within 14 days of request, unless urgently needed.
C. Manage and protect SHP members' records for 10 years.
D. Assist SHP, or our designee, in completing chart reviews for SHP members.

12.2 Risk adjustment and medical records

Appropriate medical record documentation and coding are necessary for CMS reimbursement and the accurate calculation of annual patient risk scores, which are used to adequately reflect disease burden. CMS and Samaritan Advantage conduct audits throughout the year to confirm that the Hierarchical Condition Categories (HCC) triggered for payment based on ICD-10-CM coding are supported by chart documentation. SHP obtains and audits these records, which should be provided to SHP at no cost, regardless of the methods used to process these requests.

The patient risk score represents the specific patient's disease burden for the Department of Health and Human Services (DHHS) and is reassessed each year. Points to keep in mind include the following:

A. Diagnoses do not carry forward to the following year and must be assessed and reported every year.
B. It is important to evaluate and document all medical conditions, both chronic and acute, as well as patient status during each visit and at least annually.
C. It is important to report the appropriate diagnosis codes for all documented conditions that coexist and that require or affect care at the time of the visit.
D. Encounters must be face-to-face with the patient to be eligible for risk adjustment. Telehealth visits must have both audio & video component to be considered face-to-face.

Section 13: Publications and tools

13.1 Provider directories

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

Each line of business SHP offers has a designated directory that is searchable by provider specialty, location or keyword. Provider information contained in the online directories is updated at the close of each business day from information received from SHP's provider network. Although SHP updates the online directories daily, members are encouraged to check with the provider before scheduling an appointment to confirm they are still participating. SHP cannot guarantee that providers listed in the directories are accepting new members. For Samaritan Health Plans to provide the most accurate provider information to members, please submit any changes or updates within 30 days.

13.2 Newsletters

The SHP provider e-newsletter is distributed via email on a quarterly basis to contracted providers and their support staff. The newsletter offers timely information about plan changes, education and training, quality metrics and other industry-related topics. Newly contracted providers will be automatically added to SHP's email subscriber list to receive newsletters. All providers, clinic managers and staff are encouraged to subscribe to receive these and other educational emails from SHP.

13.3 Website

SHP's website address is samhealthplans.org. The website is a frequently updated tool that will serve as one of your greatest resources. Once you have navigated to the provider section of the website, you'll find information including:

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

13.4 Provider Connect

Uses

Provider Connect is the secure provider portal that gives providers and staff access to the following:

A. Member eligibility.
B. Claim status/payment information.
C. Prior authorization requests.
D. Inpatient notification requests.
E. PCP panel management.
F. Language interpreter reporting.

Registration

Provider Connect is accessed through OneHealthPort and is available 24 hours a day. If you do not have an account with OneHealthPort, you will need to register first before you can get access to Provider Connect. To register, select the link "I'm not a OneHealthPort Subscriber but would like information on subscribing." Access is available to and encouraged for both contracted and non-contracted providers.

Assistance

Most questions related to navigating the provider portal are answered in SHP's Provider Connect tutorial. You may also contact SHP Provider Services following the guidelines in Section 2 of this manual.

Section 14: Health information technology

Health information technology (HIT) involves the exchange of health information in an electronic environment. Widespread use of HIT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork and expand access to affordable health care. All HIT platforms work together to ensure providers have access to data and resources necessary to better manage member and patient care. SHP may ask you about your use of these platforms from time to time and may be able to help connect you. It is imperative that the privacy and security of electronic health information be ensured as this information is maintained and transmitted electronically. SHP utilizes several platforms to integrate HIT into its everyday practices, such as:

14.1 Health information exchange

An HIE is the electronic movement of health-related information among organizations according to nationally recognized standards. HIE may also be referred to as a Health Information Network, as defined by the American Health Information Management Association.

14.2 Electronic health record

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

The timeliness and availability of the data will enable providers to make better decisions and provide better care. For example, the EHR can improve patient care by:

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

Additional information about the Medicare & Medicaid EHR Incentive Programs can be found on the CMS website.

14.3 PointClickCare & emergency department information exchange

PointClickCare is a web-based tool that provides real time information to support statewide efforts to reduce avoidable emergency department utilization, improve transitions of care and enhance care from inpatient settings. This coordination leads to improved member outcomes. PointClickCare enables hospital event information (ED and inpatient admissions and discharges) to be sent to health plans, CCOs, primary care, behavioral health, post-acute and specialty providers for specified member or patient populations. This information provides the ability to rapidly identify at-risk patients or members and support them in getting the right care through improved care coordination.

14.4 Unite Us

A software platform that provides electronic closed-loop referrals to other providers or community supports, proactively identifies service gaps and at-risk populations, and empowers collaborative outcomes tracking. Unite Us is used by community partners, care coordinators, health plan operations and clinical staff.

Section 15: Compliance

15.1 Compliance and integrity program and disciplinary standards

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

Copies of the Corporate Integrity Program policies and procedures, disciplinary standards, FWA prevention handbook and other compliance-related materials can be found at SHP's Compliance and Integrity webpage.

All participating SHP provider clinics must adopt and implement an effective compliance program, which must include measures that prevent, detect and correct non-compliance with state and federal program requirements, as well as fraud, waste and abuse. Training and education must occur at a minimum annually and must be a part of new employee orientation, new delegated entities and new appointment to a chief executive, manager, or governing body member. Required FWA training is developed and provided by CMS and is available through the CMS Medicare Learning Network. Once an individual completes the training, the system will generate a certificate of completion.

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

15.2 Notice of Privacy Practices and HIPAA

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

15.3 Conflict of interest

Disclosure and attestation

According to state and federal regulations, SHP is expected to regularly audit conflict of interest attestations from delegated entities. SHP requires annual completion of these certifications

because it ensures that each delegated entity has effectively screened managers, officers and directors responsible for the administration or delivery of Medicare Advantage and Part D benefits. A conflict-of-interest statement that is signed annually or upon hire, attests that the manager, officer or director is free from any conflict of interest in administering or delivering these benefits. Conflicts must be reported to the Samaritan Health Plans Compliance Department immediately upon discovery.

SHP's conflict of interest policy documents and attestation are available on the provider website.

15.4 Fraud, waste and abuse

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

A. Payment integrity:
    1. Ensure reimbursement accuracy.
    2. Keep up to date on new and emerging FWA schemes.
    3. Discover methodologies and technologies to combat FWA.
B. Special investigations units:
    1. Perform prospective and retrospective investigations of suspected FWA committed against SHP's benefit plans and programs.

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

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

Examples of fraud, waste and abuse by a provider

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

A. A provider knowingly and willfully referring a member to health care facilities in which or with which the provider has a financial relationship (Stark Law).
B. Altering claims and/or medical record documentation to get a higher level of reimbursement.
C. Balance billing a SHP member for covered services. This includes asking the member to pay the difference between the discounted and negotiated fees and the provider’s usual and customary fees.

D. Billing and providing for services to members that are not medically necessary.
E. Billing for services, procedures and/or supplies that have not been rendered.
F. Billing under an invalid place of service to receive or maximize reimbursement.

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

If you identify compliance issues and/or potential FWA, report it to SHP immediately so it can be investigated and responded to appropriately.

A. Email Samaritan Health Plans' Compliance Department at SHPOcompliance@samhealth.org.
B. Call Ethics Point Hotline: **866-297-0489** (anonymous; optional to provide your name).
C. Ethics Point Online.

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

15.5 Deficit Reduction Act of 2005

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

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

Please visit SHP's Compliance & Integrity page for more information.

15.6 False Claims Act

The False Claims Act is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including Medicare and Medicaid providers, every year. Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $13,508 to $27,018 per false claim.

15.7 Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of

HIPAA. The law makes it illegal to offer money or services that are likely to influence a member to select a particular care provider, practitioner or supplier. Examples include:

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

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

Allowable gratuities: Items or services offered to members for free must be worth less than $15 and total less than $75 per year per beneficiary. Never give cash or gift cards to members.

15.8 Exclusion checks

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

What you need to do:

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

15.9 New preclusion list policy

CMS has a preclusion list effective for claims with dates of service on or after Jan. 1, 2019. The preclusion list applies to both Medicare Advantage plans as well as Part D plans. The preclusion is comprised of a list of prescribers and individuals or entities who:

A. Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of

the Medicare program.

B. Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

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

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

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

15.10 Seclusion and restraints

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

15.11 Stark Law: Provider self-referrals

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

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

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

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

15.12 Anti-Kickback Statute

The Anti-Kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals and excessive compensation for medical directorships or consultancies. Violation of the statute constitutes a felony punishable by a maximum fine of $100,000, imprisonment up to 10 years or both.

15.13 Public health emergency

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

Section 16: Glossary of terms

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

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

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

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

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

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

Certified interpreter: A person who is certified as a competent interpreter by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. This includes passing a standardized national test.

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

Clean claim: A clean claim shall be one that:

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

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

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

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

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

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

Covered services: Medically necessary health care services and supplies that are:

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

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

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

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

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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 the health of the individual in serious jeopardy.
B. Serious impairment to bodily functions.
C. Serious dysfunction of any bodily organ or part.
D. With respect to a pregnant person who is having contractions, serious jeopardy to the health and safety of the mother or their unborn child.

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

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

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

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

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

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

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

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

IHN-CCO: InterCommunity Health Network Coordinated Care Organization.

Managed Care Entity (MCE): An entity that enters a contract to provide services in a managed care delivery system including but not limited to managed care organizations, prepaid health plans and primary care case managers.

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

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

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

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

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

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

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

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

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

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

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

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

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

a maximum amount of the plan allowable.

Post-stabilization care services: Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition.

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

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

Prioritized populations: Individuals who:

A. Are older adults, individuals who are hard of hearing, deaf, blind or have other disabilities.
B. Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports.
C. Are children ages 0 to 5 who:
    1. Show early signs of social/emotional or behavioral problems.
    2. Have a serious emotional disorder diagnosis.
D. Are in medication assisted treatment for SUD.
E. Are women diagnosed with a high-risk pregnancy.
F. Are children with neonatal abstinence syndrome.
G. Children in Child Welfare.
H. Are IV drug users.
I. People with SUD in need of withdrawal management.
J. Have HIV/AIDS or tuberculosis.
K. Are veterans and their families.
L. Are at risk of first episode psychosis, and individuals within the intellectual and developmental disability populations.

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

Provider: The person or entity that has executed the Provider Agreement, as indicated on the

signature page and who has met all credentialing and/or re-credentialing requirements. In the event the provider is a group of health care service providers, the term shall encompass all the providers associated with the provider executing the Provider Agreement.

Qualified interpreter: An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Healthcare. A qualified interpreter will have:

A. A high school diploma.
B. 60 hours interpreter training approved by the Oregon Health Authority.
C. Proof of language proficiency in English and target language.
D. Their name listed on OHA's Health Care Interpreter Registry.

Quality Improvement Program: A program designed by SHP to monitor the quality of care and services received by SHP members as covered services.

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

SHP: Samaritan Health Plans.

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

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

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

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

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

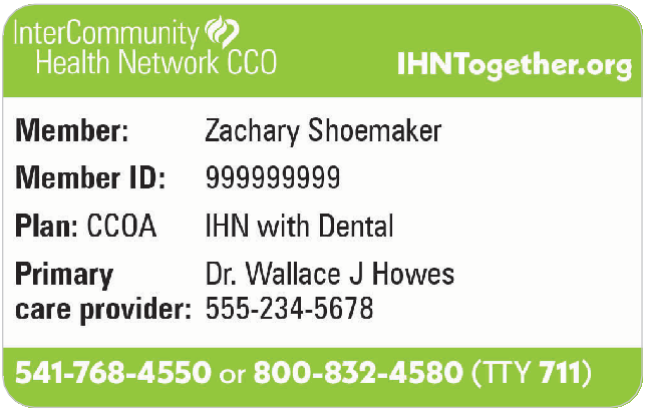
Utilization review: A set of formal techniques used by an insurer that are designed to monitor the use or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

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

Appendix

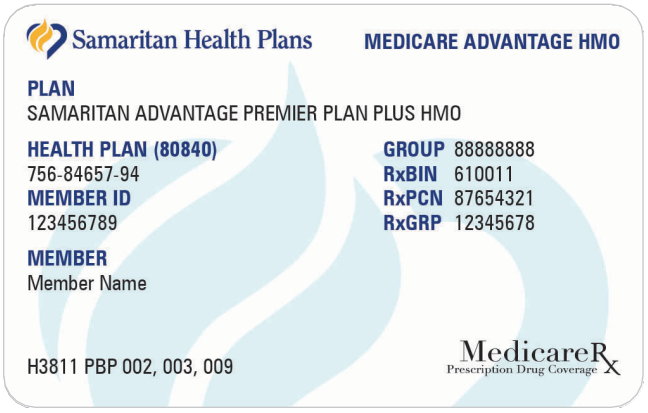
ID card samples

InterCommunity Health Network CCO (Medicaid)



Important numbers:
Emergency: **911**
Physical & behavioral health: **541-768-5207**
Pharmacy (PCN# 88888888, BIN#610011) **541-768-5207**
Rides: Ride Line, **866-724-2975**
Dental: [Dental Plan Name] **[Dental Phone]**
Vision (limited benefit): **800-832-4580**
Language access: **800-832-4580**

Samaritan Advantage Health Plans (Medicare)



[redacted]

This card does not guarantee eligibility or authorization.

FOR MEMBERS Monday – Friday, 8 a.m. to 8 p.m. PT
541-768-7866 · 866-207-3182 (TTY 800-735-2900 or 711)
HealthPlanResponse@samhealth.org · samhealthplans.org

24/7 NURSE ADVICE LINE 844-219-3816 (TTY 800-735-2900 or 711)

FOR PROVIDERS Monday – Friday, 8 a.m. to 8 p.m. PT
541-768-5207 · 888-435-2396
HealthPlanResponse@samhealth.org · providers.samhealthplans.org

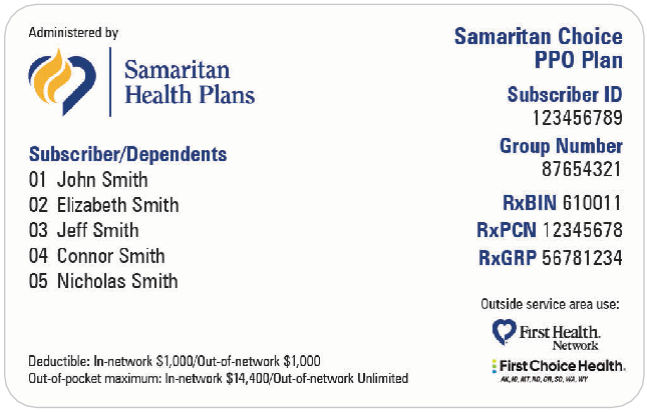
FOR PHARMACIES Call 24/7: 541-768-5207 · 888-435-2396

FOR CLAIMS Go to samhealthplans.org/claims for instructions.

Samaritan Advantage Benefits Mastercard



Samaritan Choice Plans



Administered by
Samaritan Health Plans

Samaritan Choice PPO Plan

Subscriber ID 123456789
Group Number 87654321
RxBIN 610011
RxPCN 12345678
RxGRP 56781234

Subscriber/Dependents
01 John Smith
02 Elizabeth Smith
03 Jeff Smith
04 Connor Smith
05 Nicholas Smith

Outside service area use:
First Health Network
First Choice Health

Deductible: In-network $1,000/Out-of-network $1,000
Out-of-pocket maximum: In-network $14,400/Out-of-network Unlimited

This card does not guarantee eligibility or authorization.

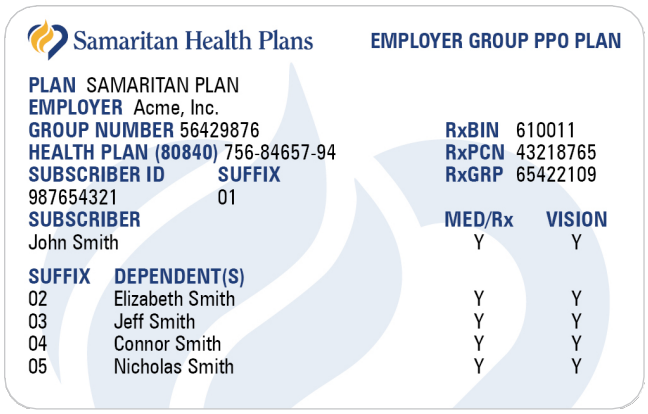
For Members
800-832-4580 · TTY **800-735-2900**
HealthPlanResponse@samhealth.org · **samhealthplans.org/Choice**

For Providers
888-435-2396 · HealthPlanResponse@samhealth.org

For Pharmacies
Call 24/7: **888-435-2396**

For Claims
Visit **samhealthplans.org/Claims**
or mail to PO Box 336, Corvallis, OR 97339

Samaritan Employer Group Plan (PPO)



Samaritan Health Plans — EMPLOYER GROUP PPO PLAN

PLAN SAMARITAN PLAN
EMPLOYER Acme, Inc.
GROUP NUMBER 56429876
HEALTH PLAN (80840) 756-84657-94
SUBSCRIBER ID 987654321
SUFFIX 01
SUBSCRIBER John Smith

RxBIN 610011
RxPCN 43218765
RxGRP 65422109

SUFFIX	DEPENDENT(S)	MED/Rx	VISION
	John Smith	Y	Y
02	Elizabeth Smith	Y	Y
03	Jeff Smith	Y	Y
04	Connor Smith	Y	Y
05	Nicholas Smith	Y	Y

This card does not guarantee eligibility or authorization.

FOR MEMBERS: Monday through Friday, 8 a.m. to 8 p.m. PT
541-768-4550 · 800-832-4580 (TTY 800-735-2900)

VISION: Limited benefit, please call 541-768-4550 for details.

FOR PROVIDERS: Monday through Friday, 8 a.m. to 8 p.m. PT
541-768-5207 · 888-435-2396 · HealthPlanResponse@samhealth.org

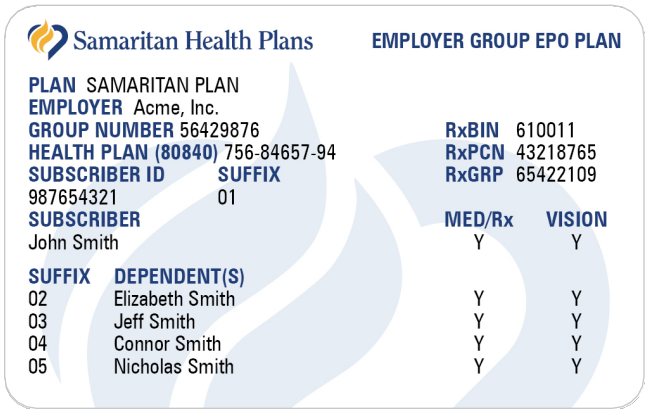
FOR PHARMACIES: Call 24/7: 541-768-5207 · 888-435-2396

FOR CLAIMS: Go to **samhealthplans.org/Claims**

	In-network	Out-of-network
Deductible	$1,000	$1,000
Out-of-pocket maximum	$14,400	Unlimited

First Choice Health
First Health Network

Samaritan Employer Group Plan (EPO)



Samaritan Health Plans — EMPLOYER GROUP EPO PLAN

PLAN SAMARITAN PLAN
EMPLOYER Acme, Inc.
GROUP NUMBER 56429876
HEALTH PLAN (80840) 756-84657-94
SUBSCRIBER ID 987654321
SUFFIX 01
SUBSCRIBER John Smith

RxBIN 610011
RxPCN 43218765
RxGRP 65422109

SUFFIX	DEPENDENT(S)	MED/Rx	VISION
	John Smith	Y	Y
02	Elizabeth Smith	Y	Y
03	Jeff Smith	Y	Y
04	Connor Smith	Y	Y
05	Nicholas Smith	Y	Y

This card does not guarantee eligibility or authorization.

FOR MEMBERS: Monday through Friday, 8 a.m. to 8 p.m. PT
541-768-4550 · 800-832-4580 (TTY 800-735-2900)
HealthPlanResponse@samhealth.org · samhealthplans.org

VISION: Limited benefit, please call 541-768-4550 for details.

FOR PROVIDERS: Monday through Friday, 8 a.m. to 8 p.m. PT
541-768-5207 · 888-435-2396 · HealthPlanResponse@samhealth.org

FOR PHARMACIES: Call 24/7: 541-768-5207 · 888-435-2396

FOR CLAIMS: Go to **samhealthplans.org/Claims**

	In-network	Out-of-network
Deductible	$1,000	$1,000
Out-of-pocket maximum	$14,400	Unlimited



2300 NW Walnut Blvd., Corvallis, OR 97330
541-768-5207 or toll free **888-435-2396**

samhealthplans.org

154513 0925