CHAPTER 409
OREGON HEALTH AUTHORITY, HEALTH POLICY AND ANALYTICS

DIVISION 36
HEALTH CARE PROVIDER INCENTIVE PROGRAM

409-036-0000
Purpose and Scope

These rules (OAR 409-036-0000 to 409-036-0150) establish the Health Care Provider Incentive Program within the Oregon Health Authority. The program offers incentives to qualified health providers who commit to serving the health care needs of medical assistance and Medicare enrollees in both rural and non-rural underserved areas of the state.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0010
Definitions

The following definitions apply to OAR 409-036-0000 to OAR 409-036-0150:

(1) “Authority” means the Oregon Health Authority.

(2) “Board” means the Oregon Health Policy Board.

(3) “Carrier” means a medical professional liability insurer holding a valid certificate of authority from the Director of the Department of Consumer and Business Services (DCBS) that authorizes the transaction of insurance as defined in ORS 731.066 and 731.072, and does not include DCBS-listed insurers pursuant to ORS 735.300 to 735.365 and 735.400 to 735.495.

(4) “Clinical Psychologist” means an individual licensed to practice psychology pursuant to ORS 675.010 to 675.090.

(5) “Clinical Social Worker” means an individual licensed to practice clinical social work pursuant to ORS 675.510 to 675.600.

(6) "DCBS” means the Department of Consumer and Business Services.

(7) “Dentist” means any individual licensed to practice dentistry pursuant to ORS 679.010.

(8) “Eligible provider” means a practitioner in Oregon delivering health care services to patients in Oregon, who meets the provider participation requirements of OAR 409-036-0060. The Board may determine eligible professions based upon the most recent assessment of health care professional need.

(9) “Essential health care services” means medical, dental or behavioral health services that have been determined to be necessary to support the health of the population of the community.

(10) “Expanded Practice Dental Hygienist” means an individual licensed to practice dental hygiene with an expanded practice dental hygienist permit issued under ORS 680.200.

(11) “Licensed Professional Counselor” has the meaning given that term in ORS 675.705.

(12) “Marriage and Family Therapist or Professional Counselor” has the meaning given that term in ORS 675.705.

(13) “Medical assistance” has the meaning given that term in ORS 414.025.

(14) “Medicare” means medical coverage provided under Title XVIII of the Social Security Act.

(15) “Naturopathic Physician” means an individual licensed pursuant to ORS 685.010 to 685.135.

(16) "Nurse Practitioner" means any individual licensed pursuant to ORS 678.375.

(17) “Office” means the Office of Rural Health has the meaning given that term in ORS 442.475.

(18) “Pharmacist” has the meaning given that term in ORS 689.005.

(19) "Physician" means any individual licensed pursuant to ORS 677.100 to 677.228.

(20) "Physician Assistant" means any individual licensed pursuant to ORS 677.495 to 677.545.

(21) "Practice full-time" means working at least 40 hours per week, with a minimum of 32 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. The Authority shall consider patient charting a component of offering direct patient care. The Authority may consider telehealth as direct patient care when the receiving site (location of the patient) is located in Oregon.

(22) “Practice part-time” means working at least 20 hours per week, with a minimum of 16 hours per week spent providing direct patient care, averaged over the month for a minimum of 45 weeks per service year. The Authority shall consider patient charting a component of offering direct patient care. The Authority may consider telehealth as direct patient care when the receiving site (location of the patient) is located in Oregon.

(23) “Program” means the Health Care Incentive Program.

(24) “Qualifying loan” means one or more government or commercial loans received solely to cover the cost of post-baccalaureate health professional training or, in the case of an expanded practice dental hygienist, undergraduate educational training. This does not include credit card loans, lines of credit, and personal loans.

(25) “Qualifying practice site” means:

(a) A rural hospital as defined in ORS 442.470 serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority, up to a maximum

requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid;

(b) A federally certified Rural Health Clinic serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority, up to a maximum requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid;

(c) A federally qualified Community Health Center serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority, up to a maximum requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid;

(d) A site other than those listed above that:

(A) Provides essential health care services to patients in an area approved as a medical, dental or mental Health Professional Shortage Area (HPSA) as defined by the federal Health Resources and Services Administration or ranking below the Areas of Unmet Health Care Need median as determined by the Office;

(B) Serves Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority, up to a maximum requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid, when a majority of providers are eligible for reimbursement from these programs for health services provided;

(C) Has a majority of providers at the site eligible for reimbursement from both Medicare and Medicaid. If a majority of providers at the site are not eligible for reimbursement from both programs, the site is qualified as long as the site serves either Medicaid or Medicare patients in no less the same proportion of such patients in the county or other service area as determined by the Authority; or

(D) Any other site providing essential health care services to an underserved population, as determined by the Authority and serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area as determined by the Authority up to a maximum requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid**.**

(26) “Telehealth” means the provision of health services from a distance using electronic communications.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0020
Types of Incentives Offered Under the Program

The types of incentives provided under this program include:

(1) **Loan Repayment subsidies** that meet the requirements of OAR 409-036-0030; to support the retention of health care providers in the area;

(2) **Loan Forgiveness payments** to support the expansion of health care workforce capacity in rural areas of the state;

(3) **Scholarships for students in health professional training programs at the Oregon Health and Science University** in a manner consistent with ORS 348.303 and meet the requirements in OAR 409-036-0040 to help students locate in rural and non-rural underserved areas;

(4) **Scholarships for students in health professional training programs at other institutions of higher learning** to help students locate in rural and non-rural underserved areas;

(5) **Community Workforce Assistance Grants** to support recruitment and retention of providers who will deliver care that supports the opportunity for people to be healthy;

(6) **Medical malpractice insurance premium subsidies** that meet the requirements in OAR 409-036-0050 and enable providers to remain practicing in rural areas of the state; and

(7) **Other incentives** as identified and directed by the Board.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0030
Eligibility Criteria specific to Loan Repayment Subsidies

(1) An eligible provider may receive a loan repayment subsidy if they are not at the same time receiving loan repayment or forgiveness under a separate, competing service obligation pursuant to ORS 676.460.

(2) The Authority may offer loan repayment subsidies based on the most recent Health Care Workforce Needs Assessment conducted by the Board, as identified in Oregon Laws 2017, Chapter 718.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0040
Eligibility Criteria specific to Scholarships for Students in Health Professional Training Programs at Other Institutions of Higher Learning

(1) Public and private institutions of higher learning in Oregon not governed by ORS 348.303 may make available scholarships using rules developed by the institution subject to the approval of the Authority that specify:

(a) The maximum amount of the scholarship;

(b) The duration of the scholarship;

(c) That scholarships shall only be available to students who commit to practicing in Oregon in areas identified by the Authority as needing providers;

(d) That successful awardees agree to serve as ambassadors for the program during participation; and

(e) That successful awardees may be asked to develop a project during their training that relate to delivery and promising practices that lead to improved health.

(2) All scholarships under this rule shall be available for future health professionals who will deliver health services in Oregon.

(3) Institutions must use scholarship money for the scholarships and funds may not be used to pay for administrative costs.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0050
Eligibility Criteria and Program Requirements specific to Medical Malpractice Insurance Premium Subsidies

(1) The Health Care Provider Incentive Fund may subsidize health care practitioners for the cost of liability insurance premiums in force, or renewed on or after the effective date of this rule.

(2) A practitioner who has a rural practice as determined by the Authority is eligible for a subsidy under the program, if the practitioner:

(a) Is not located in an urbanized area of Jackson County, as defined by the United States Census Bureau according to the most recent federal decennial census taken pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141(a), unless the practitioner is:

(A) A physician who specializes in obstetrics or who specializes in family or general practice and provides obstetrical services; or

(B) A nurse practitioner certified for obstetric care.

(b) Holds an active, unrestricted license or certification; and is

(c) Covered by a medical professional liability insurance policy issued by an authorized carrier with minimum coverage limits coverage of $1 million per occurrence and $1 million annual aggregate.

(3) A nurse practitioner employed by a licensed physician is eligible for a subsidy if covered by a medical professional liability insurance policy that names and separately calculates the premium for the nurse practitioner.

(4) A practitioner whose medical professional liability insurance coverage is provided through a health care facility, as defined in ORS 442.400, and also meets the requirements of OAR 409-036-0020(3) of this rule is eligible for a premium subsidy if the Authority determines that practitioner:

(a) Is not an employee of the health care facility;

(b) Is covered by a medical professional liability insurance policy that names the practitioner and separately calculates the premium for the practitioner; and

(c) Fully reimburses the health care facility for the premium calculated for the practitioner.

(5) A practitioner must provide an annual attestation to the Authority to be eligible to participate in the program. The Authority shall establish criteria and procedures for making the eligibility determinations and annual attestation.

(6) The Authority shall forward to each participating authorized carrier a list of eligible practitioners with respect to that provider that includes the:

(a) Practitioner's name;
(b) Practice site mailing address; and
(c) Specialty and applicable professional license or certification number issued by either the Oregon Medical Board or the Oregon Board of Nursing.

(7) To participate in the program, a carrier must provide written notice and certification to the Authority not less than 30 days prior to the beginning date of a calendar quarter, signed by an individual authorized to represent the carrier. The notice and certification must be delivered to the Authority at the following address: Oregon Health Authority, 500 Summer St NE, Salem, OR 97301, Attention: Health Care Provider Incentive Program–Medical Malpractice Insurance Subsidy.

(a) The written notification must certify that the carrier:

(A) Is a medical professional liability insurer holding a valid certificate of authority from the Director of the Department of Consumer and Business Services (DCBS) that authorizes the transaction of insurance as defined in ORS 731.066(1) and 731.072(1), and does not include DCBS listed insurers pursuant to ORS 735.300 to 735.365 and ORS 735.400 to 735.495;

(B) Understands the Authority may confirm the representations in paragraph (B) with DCBS, and that DCBS' determination about whether the carrier holds a valid certificate of authority to engage in professional liability

insurance in the state of Oregon and the other criteria in paragraph (A) shall be relied upon by the Authority in determining whether an insurer is an authorized carrier; and

(C) Agrees to comply with the terms and conditions of the rules applicable to this program in effect at the time of initial certification and those rules in effect when any request for subsidy payment is submitted to the Authority for payment.

(b) The Authority shall confirm in writing that the carrier meets the criteria as an authorized carrier. If the Authority determines that an entity is not eligible to participate as a carrier, the Authority shall provide notice to the entity of its determination and shall deny participation in the program. Entities may appeal a determination following the process set forth in OAR 409-036-0120.

(c) If an insurer fails to provide the notice and certification to the Authority within the time established, the insurer may not submit a request for premium subsidy payment for the next calendar quarter and practitioners may not receive a premium subsidy for that quarter.

(d) A carrier must notify the Authority in writing of a material change in any status or condition that relates to their eligibility to participate in the program.

(8) A carrier shall notify the Authority at least 90 days prior to the beginning date of the next calendar quarter if the carrier wants to discontinue participation in the program. The carrier shall notify its insured participating practitioners of its intent to discontinue to participate at least 60 days prior to the date of the next calendar quarter.

(9) The Authority may determine that funds available for the program are insufficient to provide maximum premium subsidy for all qualified practitioners, and the Authority may reduce or eliminate subsidies. There is no guarantee of any amount of premium subsidy provided to any carrier.

(10) Each carrier must electronically (using Microsoft Excel or similar spreadsheet application), submit a report to the Authority within 30 days after the end of each billing period (monthly or quarterly), showing the following information for each eligible practitioner who has been determined eligible for a premium subsidy as of the end of the billing quarter. The information must include the following:

(a) Carrier's name;

(b) Practitioner's name; and

(c) For each practitioner:

(A) Oregon Board of Medical Examiners license number or Oregon State Board of Nursing certification number;

(B) Practitioner's specialty and specialty class;

(C) Insurance Services Office (ISO) code;

(D) Policy number and effective date;

(E) Billing period coverage start and end dates;

(F) Billing frequency (annually, quarterly, monthly);

(G) Current in-force annual premium for coverage limits of $1 million per occurrence and up to $3 million annual aggregate;

(H) Premium subsidy percentage, calculated in accordance with 409-036-0080 (3);

(I) Dollar amount of premium subsidy, calculated in accordance with these rules;

(J) Explanation of any adjustments under this program from previous reports;

(K) Policy coverage limits;

(L) Claims-made step of practitioner, if applicable; and

(M) Identify practitioners who were not on the eligible list at the beginning of the quarter.

(d) Each January all carriers must provide the Authority with a copy of its base rates and increased limits factors table. The carrier must also inform the Authority of the base rates and increased limits factors table from their current rate filing for Oregon within 30 days of any change to those rates and table.

(e) Failure to make a timely submission may result in delay in processing the payment request. The Authority shall calculate the payment of premium subsidies from the Rural Medical Liability Subsidy Fund based on the funds available for the applicable billing period. In the event of insufficient funds, the risk of carrier delay in submission of a request for subsidy payment is on the carrier, because payments shall be based on the subsidy requests received timely for each applicable billing period.

(11) Each carrier must provide its participating practitioners with the following information each quarter:

(a) The quarterly premium due before the premium subsidy is applied;

(b) The amount of the premium subsidy;

(c) The premium after the premium subsidy is applied; and

(d) The carrier shall display these three figures on each participating practitioner's billing statement.

(12) If there are insufficient funds to provide the maximum premium subsidy to all qualifying practitioners who have applied for such subsidy, the Authority may reduce or eliminate subsidies for practitioners in an equitable manner, and shall notify affected carriers and

participants. A carrier shall reduce the premium charged to a practitioner by the amount of any premium subsidy paid or to be paid under this Program.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0060
Participation and Application Requirements

(1) Loan repayment and loan forgiveness recipients must agree to serve Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area, as determined by the Authority up to a maximum of 50 percent with at least 25 percent of which is Medicaid.

(2) Loan Repayment recipients may commit to practice full-time or part-time in a qualifying practice site for at least three years. Subject to approval by the Authority, the initial agreement may be renewed twice for additional periods of three years, or a total of nine years of service.

(3) To qualify for consideration for loan repayment a provider of essential health care services must submit an application that:

(a) Documents the individual having, or having applied for, an unrestricted license to practice in Oregon within their discipline;

(b) Includes a signed and dated statement certifying that the individual is not currently participating in the National Health Services Corps (NHSC), Nursing Corps, or State Loan Repayment Programs or the NHSC Scholarship Program or other current service obligation;

(c) Attests to the number of years that the individual is willing to make a service commitment of at least three years' work in a qualifying practice site. During that time the individual agrees to serve Medicaid and Medicare patients in the same proportion of such patients in the county or other service area as determined by the Authority up to a maximum requirement of 50 percent of patient mix for Medicare and Medicaid combined, of which 25 percent is Medicaid;

(d) Provides all other information required by the program to determine the suitability of making an award from program funds.

(3) An applicant for loan repayment subsidies that is currently employed at an eligible practice site or has an employment contract with an eligible practice site shall submit a letter attesting the site has submitted an application for participation and meets eligibility requirements for the program and provide other information as requested by the Authority.

(4) Providers receiving an insurance subsidy must be willing to make a service commitment to seeing Medicaid and Medicare patients in no less than the same proportion of such

patients in the county or other service area, as determined by the Authority up to a maximum of 50 percent with at least 25 percent of which is Medicaid.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0070
Application and Review Process

(1) As of the effective date of the filing of this proposed rule, the program is still developing the application processes. When the Authority has finalized the process, the Authority shall provide application format and submission requirements online.

(2) The Authority or its contracted designee shall review those applications that meet all requirements of OAR 409-036-0020.

(a) The Authority shall return incomplete applications, and upon resubmittal, they shall be processed as of the new date of receipt when they are determined complete.

(b) The Authority shall notify applicants of the status of their completed applications within 90 days of application submission.

(3) **The Authority may consider the following factors** in determining whether to accept an eligible provider for participation in the program, which includes but is not limited to:

(a) **Ability to obtain federally-funded incentives.** The Authority may prioritize applications from providers who apply to practice at a qualifying practice located in a higher scoring HPSA (14 and above) that has been determined may not reach the threshold for federal NHSC or NurseCorps awards in a given year.

(b) **Other determined need of the area**. The Authority may prioritize applications from providers who apply to practice at a qualifying practice located in a service area ranking below the median in the most recent Areas of Unmet Health Care Need report published by the Office.

(c) **NHSC certification status** of the practice site. The Authority may prioritize applications from providers committing to practice at a qualifying practice site certified to meet the requirements of the National Health Service Corps.

(d) **PCPCH status of the practice site**. The Authority may award priority to eligible providers who will provide services in, or in affiliation with, a Patient Centered Primary Care Home (PCPCH) recognized by the State of Oregon. The Authority may award a higher priority to those providers at a Tier 3 or higher recognized PCPCH site.

(e) **Duration of time committed to practice site, or to serving in Oregon**. The Authority may give providers priority for an award based on the duration of time they commit to serve at their practice site or in the state.

(f) **Providers located in Oregon.** In the case of a provider delivering telehealth services as all or part of their services, the Authority may give providers physically located in Oregon priority for an award.

(g) **Provider types, disciplines, or ethnic or linguistic diversity particularly needed in a community.** The Authority may give providers priority for an awardee who meets specific needs identified by a community, including ethnicity, language spoken, specialty, or provider type.

(h) **Community willingness to contribute to the cost of the award.** The Authority may give providers priority for an award if a practice site or community agrees to share in the cost of the incentive at the time of application.

(i) **Demonstrated investment in integration of behavioral health or oral health services with primary care.** The Authority may provide terms by which a provider may receive priority consideration if they are working at a site that is facilitating the integration of behavioral health and/or oral health services within the community.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0080
Maximum Award Amounts

(1) **Loan repayment subsidy recipients** are eligible for a maximum loan repayment award in the following manner:

(a) Full-Time Service:

(A) Fifty percent of the balance owed on qualifying loans upon program entry for an initial three years of service;

(B) Sixty percent of the balance owed on remaining qualifying loans for an additional three years of service;

(C) Seventy percent of the balance owed on remaining qualifying loans for a final three years of service; and

(D) A participant may receive no more than $35,000 in a single year for full-time service.

(b) Part-Time Service:

(A) Twenty-five percent of the balance owed on qualifying loans upon program entry for an initial three years of service;

(B) Twenty-five percent of the balance owed on remaining qualifying loans for an additional three years of service;

(C) Twenty-five percent of the balance owed on remaining qualifying loans for a final three years of service; and

(D) A participant may receive no more than $25,000 in a single year for part-time service.

(2) **Scholarship and Loan Forgiveness recipients** are eligible for incentives as follows:

(a) Scholarship recipients under the Scholars for a Healthy Oregon Initiative at Oregon Health and Science University shall receive a scholarship covering the entire cost of tuition and fees for the participant's health care education at the university.

(b) Students attending other educational institutions shall receive a scholarship or loan forgiveness covering an amount equal to at least half of and up to the entire cost of tuition and fees for the participant's health care education in the program in which they are participating, at the discretion of the institution, so long as the maximum scholarship for each student does not exceed the highest resident tuition rate at the publicly-funded health professional training programs in this state.

(3) **Insurance Subsidy Recipients**. Practitioners in the program who receive an insurance subsidy shall receive a maximum subsidy of:

(a) Eighty percent of the actual premium charged for physicians specializing in obstetrics and nurse practitioners certified for obstetric care;

(b) Sixty percent of the actual premium charged for physicians specializing in family or general practice who provide obstetrical services;

(c) Forty percent of the actual premium charged for physicians and nurse practitioners engaging in one or more of the following practices:

(A) Family practice without obstetrical services;

(B) General practice without obstetrical services;

(C) Internal medicine;

(D) Geriatrics;

(E) Pulmonary medicine;

(F) Pediatrics;

(G) General surgery; or

(H) Anesthesiology;

(d) Fifteen percent of the actual premium charged for physicians and nurse practitioners other than those included in OAR 409-036-0080 (3)(a)-(c).

(4) **Other subsidies.** The Authority may provide grants to an organization to support innovative or evidence-based practices for recruitment and retention of health care providers.

Stat. Auth.: OL 2017, Ch. 718

Stats. Implemented: OL 2017, Ch. 718

409-036-0090
Transfer of Provider Service Obligation to Another Site

(1) In the event of a practice failure or other extenuating circumstance, a participating provider with Authority approval may transfer the service obligation to another qualifying practice site. This is intended to be a rare instance and may not be granted without prior approval. A transfer without prior approval is considered a violation of the service agreement. A participating provider must submit a written transfer request to the Authority documenting the:

(a) Circumstances surrounding the need to transfer;

(b) Proposed new qualifying practice site; and

(c) Name of the director or administrator at the proposed new practice site.

(2) The participating provider must also submit:

(a) A letter from the original practice site releasing the eligible provider from any employment contract (if applicable) and providing an explanation for the termination of employment. The Authority may waive this requirement if the original practice site is in non-compliance with federal requirements, federal or state law, or these rules.

(b) An employment contract with the new qualifying practice site, a letter of intent from the new qualifying practice site to employ the provider, or documentation of the provider having established a sole proprietorship, Limited Liability Corporation, Limited Liability Partnership, or Professional Corporation that meets the definition of a qualifying practice site.

(3) The new practice site, in collaboration with the provider, must:

(a) Submit a letter of support documenting the site meets the definition in OAR 409-036-0010 (25) and providing other information as requested by the Authority.

(b) Provide confirmation that the site will cooperate with the provider to comply with the monitoring and follow-up requirements set forth in these rules.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0100
Suspension or Waiver of Minimum Service Obligation

(1) The Authority may agree to suspend a participating provider's service obligation for a specified time under circumstances it deems appropriate, including, but not limited to parental leave, medical leave, military service leave, or other factors beyond a provider's control. During the time of suspension, awards shall be suspended.

(2) A participant requesting a suspension of minimum service obligation shall make a written request to the Authority, citing the reasons and providing documentation of the circumstances.

(3) The Authority may waive all or part of the minimum service obligation under the following circumstances:

(a) Upon receipt of written documentation acceptable to the Authority of the death of the participant;

(b) Upon receipt of written documentation acceptable to the Authority of the total and permanent disability of the participant; or

(c) Upon receipt of written documentation of other significant changes in life circumstances that are out of the control of the participant and that the Authority determines warrant a waiver of service commitment.

(4) If all or part of the minimum service obligation is waived, the Authority may not impose any penalty for failure to meet the obligation.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0110
Monitoring and Follow-up Requirements

(1) To maintain participation in the program, a provider must:

(a) Notify the Authority immediately upon beginning work at a qualifying practice site.

(b) Promptly submit semi-annual reports signed by the provider and the administrator of the qualifying practice site verifying the provider's employment, or licensed business(in the case of a sole provider), and providing any additional information as requested by the Authority, including but not limited to:

(A) Site's and Provider's caseload (panel size or equivalent);

(B) Site's and Provider's Medicaid caseload and Medicare caseload;

(C) Provider full-time equivalent (FTE) status; and

(D) Number and percentages of practice site's patients whose health care is covered by Medicaid and by Medicare, and the number of patients at the practice site who are uninsured.

(2) The first report is due six months after employment begins, and every six months thereafter, until the term of the contract is complete.

(3) A provider participating in the program must notify the Authority immediately of any change in employment or practice status.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0120
Failure to Comply; Penalties & Appeals

(1) **A loan repayment recipient** who fails to complete the minimum service obligation in a qualifying practice site and does not receive a waiver shall be considered to have breached the terms of the program. The Authority shall impose a penalty on any such provider in an amount up to the sum of:

(a) The total paid from the Health Care Provider Incentive Fund to the participant or on behalf of the participant for any periods of obligated service not served;

(b) $7,500 for each month of the minimum service period not completed according to the terms of the obligation; and

(c) Interest on the above amounts at the maximum prevailing rate, as determined by the Oregon Department of Revenue, calculated from the date of breach until full repayment has been made.

(d) The participant may appeal decisions made by the Authority under the provisions of ORS Chapter 183.

(2) **A loan forgiveness or scholarship recipient** who fails to complete the minimum service obligation in a qualifying practice site and does not receive a waiver is considered to have breached the terms of the program. The Authority shall impose a penalty on any such provider in an amount up to the sum of:

(a) The total paid from the from the Health Care Provider Incentive Fund to the participant or on behalf of the participant plus 10 percent interest for failure to complete the recipient's academic program;

(b) The total paid from the from the Health Care Provider Incentive Fund to the participant or on behalf of the participant plus 10 percent interest plus a 25percent penalty on the total award paid to date for failure to complete a service agreement. The Collections Unit in the Oregon Department of Revenue shall collect amounts due under ORS 293.250.

(c) The participant may appeal decisions made by the Authority under the provisions of ORS Chapter 183.

(3) A carrier found to be in breach of their agreement under this program is subject to penalties. Administrative review, for purposes of these rules, shall be the process for any appeals made to the Authority. A carrier or practitioner may request administrative review. The Authority must receive the request in writing no later than 30 calendar days after the date of the Authority's notice. If the request for administrative review is timely, the practitioner or the carrier must provide the Authority with a copy of all relevant records and other materials relevant to the appeal, no later than 10 days before the review is scheduled.

(a) If the Authority decides that a preliminary meeting between the practitioner or carrier and Authority staff may assist the review, the Authority shall notify the individual requesting the review of the date, time, and place the meeting is scheduled.

(b) The Authority shall conduct the administrative review meeting as follows:

(A) No minutes or transcript of the review shall be made;

(B) The carrier or practitioner requesting review does not have to be represented by counsel during an administrative review meeting and shall be given the opportunity to present relevant information;

(C) Authority staff may not be available for cross-examination, but may attend and participate in the review meeting;

(D) Failure to appear without good cause constitutes acceptance of the Authority's determination;

(E) The Authority may combine similar administrative review proceedings and meetings involving the same parties or similar facts, if the Authority determines that joint proceedings may facilitate the review;

(F) The Authority may request the appealing practitioner or carrier to submit, in writing, new information that has been presented orally. The Authority shall establish the deadline for submission of the information.

(c) The Authority shall send the results of the administrative review to the participant involved in the review, within 30 calendar days of the conclusion of the administrative review meeting, or such time as may be agreed to by the participant or designated by the Authority.

(d) The Authority's final decision on administrative review is the final decision on appeal and binding on the parties. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Authority's final decision on administrative review.

(e) Academic institutions providing admission-based scholarships may set penalties for default against the terms of their program.

Stat. Auth.: OL 2017, Ch. 718

Stats. Implemented: OL 2017, Ch. 718

409-036-0130
Contributions to the Health Care Provider Incentive Fund

(1) The Authority shall publish on its website terms and conditions for receipt of funds from qualifying practice sites or other sources to contribute toward the cost of the subsidies for participants.

(2) The Authority shall deposit all contributions to the Health Care Provider Incentive Fund established in ORS 676.450.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409- 036-0140
Program Integrity

(1) The Authority shall analyze and monitor the operation of the program and audit and verify the accuracy and appropriateness of all payments made under the terms of this program. To promote the integrity of the program, the Authority may require participants and any other parties to develop and maintain adequate financial and other documentation as determined by the Board to be necessary. The Authority may communicate with and coordinate any program integrity actions with the federal and state oversight authorities.

(2) Any overpayment made to an individual or carrier is subject to recovery. The Authority shall take appropriate action and may redress payment errors or false claims for payment under the program.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718

409-036-0150
Data Sharing

(1) The Authority may not share data about program participants, other than for purposes of planning, program evaluation or analysis.

(2) Data may only be shared with:

(a) Agencies, offices, or contractors of the Authority;

(b) The Oregon Employment Department; and

(c) Non-governmental not noted above only with written approval from the Director of the Authority.

Stat. Auth.: OL 2017, Ch. 718
Stats. Implemented: OL 2017, Ch. 718