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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 74-2024
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED
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SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Addition of Health-Related Social Needs (HRSN) Service Provider Qualifications

EFFECTIVE DATE: 03/01/2024 THROUGH 08/27/2024

AGENCY APPROVED DATE: 02/23/2024

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NEED FOR THE RULE(S):

The delivery of HRSN, a new series of benefits under the 1115 Medicaid Waiver, requires a new type of provider, and subsequently new provider qualifications. HRSN services aim to address the social and economic needs that impact an individual's ability to maintain their health and well-being. HRSN Service Providers will assist in delivering the new HRSN Services to OHP Members.

JUSTIFICATION OF TEMPORARY FILING:

(1) A temporary filing of provider qualifications must be in place prior to the go-live date of HRSN Services, beginning with climate related services in March of 2024. CCOs and OHA must begin to recruit, enroll, credential and enroll HRSN Service Providers prior to and in the beginning of the benefit go-live for climate related services. Provider qualifications must be in OAR for this process to be enforceable and appealable. This rule was unintentionally excluded from the RAC held in November that contains the other HRSN related OARs. This will go through the appropriate RAC, comment period, and permanent filing within a few months of this temporary rule.

(2) HRSN eligible OHP members, possible community-based organizations, Coordinated Care Organizations.

(3) Provider qualifications must be in place prior to enrolling HRSN providers. HRSN Providers are key to the service delivery of the new HRSN Services. Without these in place, access to HRSN services by OHP Members may be delayed or limited.

(4) Temporary filing of provider qualifications will allow CCOs and OHA to enroll appropriate HRSN Service Providers with the right qualifications sooner, ensuring time access to benefits for Members. These provider qualifications have been reviewed and co-created in work sessions with CCOs, lessening the possible negative impacts of this temporary process.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

AMEND: 410-141-3510

RULE SUMMARY: Provider Contracting and Credentialing

CHANGES TO RULE:

410-141-3510
Provider Contracting and Credentialing
(1) M~~CEs~~anaged Care Entity's (MCEs) shall develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards~~:~~.¶
(a) MCEs shall ensure that all participating providers as defined in OAR 410-141-3500 providing coordinated care services to members are credentialed upon initial contract with the MCE and re-credentialed no less frequently than every three (3) years. The credentialing and re-credentialing process shall include review of any information in the National Practitioners Databank. MCEs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application;¶
(b) MCEs shall screen their participating providers to be in compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes, except in the following circumstances for credentialing COVID-19 vaccine administration providers for the sole purpose of administering COVID-19 vaccines or the administration of the flu vaccine when administered in conjunction with the COVID-~~-~~19 vaccination. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the Authority's Public Health Division to be a COVID-19 vaccination administration provider, completed all required training, and has agreed to all terms of program participation.¶
(A) ~~CCO~~MCEs may rely upon the most recent weekly update of the Authority's active file of vaccine administration providers to meet contractual and regulatory requirements for credentialing COVID-19 vaccine administration providers.¶
(B) ~~CCO~~MCEs may enroll COVID-19 vaccine administration providers who are included in the Authority's most recent active file of vaccine administration providers.¶
(C) ~~CCO~~MCEs shall monitor changes in the Authority's weekly active file of vaccine administration providers for terminations and changes.¶
(c) MCEs shall screen their contracted HRSN Services Providers to be in compliance with 42 CFR □□ 455.410 through 455.436, 455.450, 455.452, and 455.470, and retain all resulting documentation for audit purposes.¶
(d) MCEs may elect to contract for or ~~to~~ delegate responsibility for the credentialing and screening processes; however, ~~CCO~~MCEs shall be solely and ultimately responsible for adhering with all terms and conditions held in its contract with the state. For the following activities including oversight of the following processes regardless of whether the activities are provided directly, contracted, or delegated, MCEs shall:¶
(A) Ensure that coordinated care services are provided within the scope of license or certification of the participating provider or facility and within the scope of the participating provider's contracted services. They shall ensure participating providers are appropriately supervised according to their scope of practice;¶
(B) Provide training for MCE staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the MCEs administrative policies.¶
(~~d~~e) The MCE shall provide accurate and timely information to the Authority about:¶
(A) License or certification expiration and renewal dates;¶
(B) Whether a provider's license or certification is expired or not renewed or is subject to licensing termination, suspension, or certification sanction;¶
(C) If an MCE knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere");¶
(D) If an MCE removes a provider or fails to renew a provider's contract if the provider fails to meet objective quality standards.¶
(~~e~~f) MCEs may not refer members to or use providers that:¶
(A) Have been terminated from Medicaid;¶
(B) Have been excluded as a Medicaid provider by another state;¶
(C) Have been excluded as Medicare/Medicaid providers by CMS; or¶
(D) Are subject to exclusion for any lawful conviction by a court for which the provider ~~could~~may be excluded under 42 CFR 1001.101.¶

(~~f~~g) MCEs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. MCEs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;¶
(~~g~~h) MCEs shall require each atypical provider to be enrolled with the Authority ~~and shall~~. MCEs shall also require each atypical provider, except HRSN Service Providers, to obtain and use registered National Provider Identifiers (NPIs), and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. MCEs shall require each qualified provider, except HRSN Service Providers, to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES).;¶
(~~h~~i) The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.¶
(2) An MCE may not discriminate with respect to participation in the MCE against any health care provider who is acting within the scope of the provider's license or certification under applicable state law on the basis of that license or certification. If an MCE declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This rule may not be construed to:¶
(a) Require that an MCE contract with any health care provider willing to abide by the terms and conditions for participation established by the MCE; or¶
(b) Preclude the MCE from establishing varying reimbursement rates based on quality or performance measures. For purposes of this section, quality and performance measures include all factors that advance the goals of health system transformation including:¶
(A) Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or¶
(B) Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.¶
(c) The requirements in subsection (2)(b) of this rule do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.¶
(3) An MCE shall establish an internal review process for a provider aggrieved by a decision under section (2) of this rule including an alternative dispute resolution or peer review process. An aggrieved provider may appeal the determination of the internal review to the Authority.¶
(4) To resolve appeals made to the Authority under sections (2) and (3) of this rule, the Authority shall provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the MCE to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority shall consider the MCE's:¶
(a) Network adequacy;¶
(b) Provider types and qualifications;¶
(c) Provider disciplines; and¶
(d) Provider reimbursement rates.¶
(5) A prevailing party in an appeal under sections (3) through (4) of this rule shall be awarded the costs of the appeal.¶
(6) MCEs shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a.¶
(7) MCEs shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.¶
(8) MCEs shall offer contracts to all Medicaid eligible IHCPs and to provide timely access to specialty and primary care within their networks to MCE enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the MCE network.¶
(9) MCEs shall ensure that all contracted HRSN Service Providers meet the specific provider qualifications to

provide HRSN Services to Members who are authorized by the MCEs to receive HRSN Services (HRSN-Authorized Members). Contracted HRSN Service Providers must:¶
(a) Be accessible to Members, including having the operating hours and the staff necessary to meet the Members' needs.¶
(b) Demonstrate their ability or experience to effectively serve at least one of OHA's Priority Populations, as defined in ORS 413.042. ¶
(c) Demonstrate they employ or contract with administrative and service delivery staff, who are, as reasonably determined by the MCE, qualified to perform and fulfill the responsibilities of their jobs. ¶
(d) Demonstrate they provide culturally and linguistically appropriate, responsive and trauma-informed services, which includes the ability to: ¶
(A) Supply (i) language interpretation and translation services to those Members who have limited English proficiency, and (ii) American Sign Language (ASL) services for to those Members who require ASL in order to communicate; and ¶
(B) Respond to the cultural needs of the diverse populations they serve by performing services in accordance with National CLAS Standards. ¶
(e) Documented demonstration of a history of responsible financial administration via recent annual financial reports, an externally conducted audit, or other similar documentation.¶
(f) Meet readiness standards defined by the Authority, including providing the MCE with an attestation of their agreement or ability (or both agreement and ability) to comply with all of the following:¶
(A) Reporting and oversight requirements established by the Authority or the MCE or, as applicable, both; ¶
(B) All laws relating to information privacy and security applicable to their business; ¶
(C) Compliance with the credentialing obligations under section (1)(c) of this rule; ¶
(D) All obligations related to participating in the Closed Loop Referral process (acceptance and confirmation); and¶
(E) Invoicing for HRSN Services as agreed upon in their contract with the MCE to provide HRSN Services.¶
(g) Comply with oversight requirements established by the Authority, or the MCE, (or both as applicable), and all laws relating to privacy and security that are applicable to their business.¶
(h) Agree to be enrolled as "encounter only" providers in MMIS, OHA's electronic system that processes Medicaid claims. The MCE shall enroll their contracted HRSN Service Providers as "encounter only" providers in MMIS.¶
(10) It is preferred that MCEs contract with HRSN Service Providers providing Climate-Related Supports that are capable of both delivering and installing Climate-Related Devices. In the event an HRSN Service Provider does not provide installation services, MCEs shall ensure installation services are also performed by a different qualified HRSN Services Provider or HRSN vendor(s).¶
(11) MCEs shall, and shall ensure that HRSN Service Providers providing HRSN Outreach and Engagement Services, assign the responsibility for performing HRSN Outreach and Engagement Services to only those staff who have knowledge of principles and methods, as well as the experience and skills that enables them to effectively engage with individuals who are the intended beneficiaries of HRSN Services for the purpose of connecting them to the HRSN Services and other benefits and services that shall meet their needs.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, 414.727