



TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 10-2021

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED

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ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Suspension of Credentialing Requirements of COVID-19 Vaccination Providers for Coordinated Care Organizations (CCOs)

EFFECTIVE DATE: 03/15/2021 THROUGH 09/10/2021

AGENCY APPROVED DATE: 03/15/2021

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NEED FOR THE RULE(S):

The Division needs to amend this rule in an effort to expedite enrollment of COVID-19 vaccination providers by CCOs. This action will help improve access to COVID-19 vaccines as supply increases for Oregon Health Plan members. CCOs will rely on enrollment and screening information provided by OHA based on permissions granted by the Center for Medicare and Medicaid Services (CMS).

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may improve efficiencies for CCOs by transmitting provider screening information to CCOs to expedite their ability to onboard COVID-19 vaccination providers which will expand access to the COVID-19 vaccination for Oregon Health Plan members.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

N/A

AMEND: 410-141-3510

RULE TITLE: Provider Contracting and Credentialing

RULE SUMMARY: This rule change suspends CCO provider credentialing requirements for COVID-19 vaccination providers only. OHA will provide CCOs with screening information on a weekly basis to inform CCO provider enrollment decisions. By expediting this process, CCOs can expedite their ability to onboard new COVID-19 vaccination providers which will expand access to the COVID-19 vaccines for Oregon Health Plan members.

RULE TEXT:

- (1) 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 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. For the purpose of this rule, COVID-19 vaccination administration provider means a healthcare provider that has successfully enrolled with the OHA'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) CCOs may rely upon the most recent weekly update of OHA's active file of vaccine administration providers to meet contractual and regulatory requirements for credentialing COVID-19 vaccine administration providers.

(B) CCOs may enroll COVID-19 vaccine administration providers who are included in OHA's most recent active file of vaccine administration providers.

(C) CCOs shall monitor changes in OHA's weekly active file of vaccine administration providers for terminations and changes.

(c) MCEs may elect to contract for or to delegate responsibility for the credentialing and screening processes; however, CCOs 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) 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) 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 be excluded under 42 CFR 1001.101.

(f) 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) MCEs shall require each atypical provider to be enrolled with the Authority and shall 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 to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES);

(h) 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 (b) 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 (4) 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 (3) and (4) 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.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.615, 414.625, 414.635, 414.651

STATUTES/OTHER IMPLEMENTED: ORS 414.610 - 414.685