

Secretary of State
NOTICE OF PROPOSED RULEMAKING HEARING*
A Statement of Need and Fiscal Impact accompanies this form.

<u>Oregon Health Authority, Division of Medical Assistance Programs (Division)</u>	410
Agency and Division	Administrative Rules Chapter Number
<u>Sandy Cafourek 500 Summer St Ne, Salem, OR 97301</u>	503-945-6430
Rules Coordinator Address	Telephone

RULE CAPTION

Clarification of Credentialing Approval and Denial Protocol and Provider Discrimination Recourse Process
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

<u>May 15, 2015</u>	10:30AM	500 Summer St NE, Salem, OR 97301, Room 166	Sandy Cafourek
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-141-0120 and OAR 410-141-3120

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth: ORS 413.042, 414.615, 414.625, 414.635 and 414.651

Other Auth.:

Stats. Implemented: ORS 413.042, 414.615, 414.625, 414.635 and 414.651

RULE SUMMARY

The Division of Medical Assistance Programs (Division) needs to amend these rules to comply with recommendations from the Integrated Medicine Advisory Group (IMAG) that serves as an advisory forum to the Oregon Health Authority (Authority), appointed by the Authority director. The intent of these recommendations is to give healthcare providers written documentation from the Oregon Health Plan contracted health plans in response to their credentialing applications and to do so within a 90-day time period from the date a completed application packet is received by the health plan. The written documentation will also serve as the vehicle for submission to the plan's discrimination review panel and/or the OHA Provider Discrimination Review Committee, should the provider receive and wishes to appeal a negative response. In addition, the Division needs to amend these rules in order to revise the language with current credentialing processes and align the MCO rules with the CCO rules, as appropriate.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

May 18 SC
March 18, 2015

XX-XXX

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)



David Simowitz

3/18/2015

Signature

Printed name

Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Division of Medical Assistant Programs (Division)

410

Agency and Division

Administrative Rules Chapter Number

Rule Caption

Clarification of credentialing approval and denial protocol and provider discrimination recourse process.
(Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: OAR 410-141-3120 and OAR 410-141-0120

Statutory Authority: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Other Authority:

Stats. Implemented: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Need for the Rule(s): The Division of Medical Assistance Programs (Division) needs to amend these rules to comply with recommendations from the Integrated Medicine Advisory Group (IMAG) that serves as an advisory forum to the Oregon Health Authority (Authority), appointed by the Authority director. The intent of these recommendations is to give healthcare providers written documentation from the Oregon Health Plan contracted health plans in response to their credentialing applications and to do so within a 90-day time period from the date a completed application packet is received by the health plan. The written documentation will also serve as the vehicle for submission to the plan's discrimination review panel and the OHA Provider Discrimination Review Committee, should the provider receive and wishes to appeal a negative response. In addition, the Division needs to amend these rules in order to revise the language with current credentialing processes and align the MCO rules with the CCO rules, as appropriate.

Documents Relied Upon, and where they are available: Integrative Medicine Credentialing Information Tool-Winter 2014, http://transformationcenter.org/wp-content/uploads/2015/01/IMAG-Credentialing-Tool_FINAL_012015.pdf

Fiscal and Economic Impact: These rules are not expected to have significant fiscal impact. The processes outlined within the rules are currently being administered within the health plan organizations. Only the timeframes in which the work is carried out might be affected. Written responses may or may not change the protocol of a plan and will vary by plan. The impact is not expected to be significant.

Statement of Cost of Compliance: None anticipated

1. Impact on state agencies, units of local government, and the public (ORS 183.335(2)(b)(E)): None anticipated

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: None anticipated

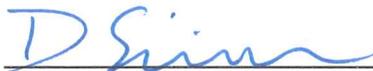
b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: None anticipated

c. Equipment, supplies, labor and increased administration required for compliance: None anticipated

How were small businesses involved in the development of this rule? Small businesses were invited to participate in the RAC.

Administrative Rule Advisory Committee consulted?: RACs were held on February 10 , 2015 and February 26 , 2015.

If not, why?:



Signature

DAVID SIMMITT

Printed name

3/18/2015

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

Managed Care Prepaid Health Plan Provision of Health Care Services

~~(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and ancillary services, and in those categories of services included in contract or agreements with the Division of Medical Assistance Programs (Division) and Addictions and Mental Health (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:~~

~~(a) PHPs shall ensure that all participating providers providing covered services to Division members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination based on the requirements of the discipline or profession that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges, and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities including oversight of the following processes:~~

~~(A) PHPs shall ensure that covered 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 and that participating providers are appropriately supervised according to their scope of practice;~~

~~(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, Oregon Health Plan (OHP) administrative rules, and the PHP's administrative policies;~~

~~(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and shall provide accurate and timely information about license or certification expiration and renewal dates to the Division. PHPs may not refer Division members to or use providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or~~

certification is expired or not renewed or is subject to licensing or certification sanction, the PHP shall immediately notify the member's Provider Services Unit.

~~(D) PHPs may not refer members to or use providers who have been terminated from the Division or excluded as Medicare and Medicaid providers by Centers for Medicare and Medicaid (CMS) or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs may not accept billings for services to members provided after the date of such provider's exclusion, conviction, or termination. The Oregon Health Authority (Authority) has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they shall submit to their Coordinated Care Account Representative (CAR) for Authority approval prior to use. PHPs shall obtain information required on the appropriate disclosure form from individual practitioners and entities and shall retain the disclosure statements in the PHP credential files. If a PHP 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"), the PHP shall immediately notify the Division's Provider Services Unit.~~

~~(E) PHPs shall obtain and use the Division's provider enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number "999999" may no longer be used in encounter data reporting or provider capacity reporting. PHPs shall require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).~~

~~(F) The provider enrollment request (for encounter purposes) and disclosure statement described in paragraphs (D) and (E) require the disclosure of taxpayer identification numbers. The taxpayer identification number will be used for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, administration of tax laws, and may be used 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 the Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification number(s) may result in denial of enrollment as a provider, denial of a provider number for encounter purposes, denial of continued enrollment as a provider, and deactivation of all provider numbers used by the provider for encounters.~~

(1) MCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, MCOs shall provide medically appropriate health services within the scope of the member's benefit package of health services, in accordance with the Prioritized List of Health Services and the terms of the contract. MCOs shall also provide other non-medical services designed to provide health-related and cost-effective alternatives to more technical services and reported as "health-related services" defined in OAR 410-141-0000, accounted for in the MCO's medical or member service expenses.

(3) MCOs shall select providers using accepted standards for application and credentialing procedures and objective quality information. MCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards:

(a) MCOs shall ensure that all participating providers providing services to members are credentialed upon initial contract with the MCO and recredentialed no less frequently than every three years. The credentialing and recredentialed process shall include review of any information in the National Practitioners Databank. MCOs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialed Application. MCO's shall process all complete credentialing and recredentialed applications, including required documents, certificates and licenses, within the 90-day credentialing period;

(b) MCOs shall screen their 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;

(c) MCOs may elect to contract for or to delegate responsibility for the credentialing, recredentialed, and screening processes; however, MCOs shall be responsible for the following activities including oversight of the following processes, regardless of whether the activities are provided directly, contracted, or delegated:

(A) Ensuring 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) Providing training for MCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the MCOs administrative policies.

(d) The MCO 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 MCO 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”).

(e) MCOs may not refer members to or use providers that:

(A) Have been terminated from the Division;

(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) MCOs may not accept billings for services to members provided after the date of the provider’s exclusion, conviction, or termination. MCOs shall recoup any monies paid for services to members provided after the date of the provider’s exclusion, conviction, or termination;

(g) MCOs 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 Delivery System Network Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. MCOs 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.

(4) In accordance with ORS 414.646, an MCO may not discriminate with respect to participation in the MCO 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. This rule may not be construed to:

(a) Require that an MCO contract with any health care provider willing to abide by the terms and conditions for participation established by the MCO; or

(b) Preclude the MCO 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) If an MCO declines to include individual or groups of providers in its network, it shall, within the 90-day credentialing period, give the affected providers written notice of the reason for its decision. If there is no written response to the individual or groups of providers within the 90-day credentialing period, the affected providers may appeal to the MCO, provided the plan has an internal review process. It is the provider's option to use the MCO's discrimination review process. If the MCO does not have an internal discrimination review process or if the provider elects to not use the plan review process, the affected providers may appeal directly to OHA through the Provider Discrimination Review process.

(5) An MCO may establish an internal discrimination review process for a provider aggrieved by a decision under sections (4) through (6) of this rule, including an alternative dispute resolution. If unsatisfied with the MCO's written decision, providers may request an appeal of the decision through the plan's internal discrimination review process, provided the MCO has such a process.

(6) An aggrieved provider may appeal the determination of the MCO's internal discrimination decision to the Authority. The provider may ask the Authority to reconsider the decision, even if the MCO does not have a provider discrimination review process, if the provider believes the MCO has discriminated against the provider on the basis of their licensure. To make such a request, the provider may submit form DMAP 2120, OHA Provider Discrimination Review Request.

(7) To resolve discrimination appeals made to the Authority under sections (4) through (7) of this rule, the Authority shall provide review of the provider's discrimination appeal using the OHA Provider Discrimination Review Process. The Authority shall invite the aggrieved provider and the MCO to participate in the Provider Discrimination Review. In making a determination of whether there has been discrimination, the Authority shall consider the MCO's:

(a) Network adequacy;

(b) Provider types and qualifications and credentialing qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(8) The Authority shall respond in writing to the individual or groups of providers. The written response shall occur within 100 days of the receipt by the Authority of the completed DMAP 2120 form or the receipt of any outstanding documentation needed to resolve the appeal, whichever is later.

(9) As specified in ORS 414.646, a prevailing party in an appeal, under sections (4) through (7) of this rule, shall be awarded the costs of the appeal.

(b10) FCHPs, Physician Care Organization (PCOs), and Dental Care Organizations (DCOs) shall have written procedures that provide newly enrolled members with information about how to request information on which participating providers are and those not currently not accepting new patients (except for staff models);

(e11) FCHPs, PCOs, and DCOs shall have written procedures that allow and encourage a choice of a Primary Care Provider (PCP) or clinic for physical health and dental health services by each member. These procedures shall enable a member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that member;

(d12) If the member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO shall ensure the member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign members to PCPs or clinics shall document the unsuccessful efforts to elicit the member's choice before assigning a member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after enrollment shall notify the member of the assignment and allow the member 30 calendar days after assignment to change the assigned PCP or clinic.

(213) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to the member's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) The following services may be received by Division members from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), the member is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and planning committees;

(e) FCHPs and PCOs shall report to the Division on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(314) FCHPs and PCOs shall ensure a newly enrolled member receives timely, adequate, and appropriate health care services necessary to establish and maintain the health of the member. An FCHP's liability covers the period between the member's enrollment and disenrollment with the FCHP, unless the member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient

hospital services until discharge or until the member's PCP or designated practitioner determines the care is no longer medically appropriate.

(415) A PCO's liability covers the period between the member's enrollment and disenrollment with the PCO, unless the member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services ~~will~~shall be the responsibility of the Division.

(516) The member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(617) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services and shall coordinate benefits for shared members to ensure that the member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible member is enrolled in a FCHP or PCO with a Medicare HMO component, the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(718) PHPs shall coordinate services for each member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health or dental care for that member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer members to the divisions of the Authority and local and regional allied agencies that may offer services not covered under the capitation payment;

(c) FCHPs and PCOs may not require members to obtain the approval of a PCP in order to gain access to mental health and Substance Use Disorder assessment and evaluation services. Division members may refer themselves to MHO services.

410-141-3120

Operations and Provision of Health Services

(1) CCOs shall establish, maintain, and operate with a governance structure and community advisory council that is consistent with the requirements of ORS 414.625 and applicable health system transformation laws.

(2) At a minimum, CCOs shall provide medically appropriate health services ~~including flexible services within the scope of the member's benefit package of health services,~~ in accordance with the Prioritized List of Health Services and the terms of the contract. CCOs shall also provide other non-medical services designed to provide health-related and cost-effective alternatives to more technical services and reported as "health-related services" defined in OAR 410-141-0000, accounted for in the CCO's medical or member service expenses in Exhibit L of the CCO Contract.

(3) CCOs shall select providers using ~~universal~~ accepted standards for application and credentialing procedures and objective quality information. CCOs shall take steps to remove providers from their provider network if they fail to meet objective quality standards:

(a) CCOs shall ensure that all participating providers providing coordinated care services to members are credentialed upon initial contract with the CCO and recredentialed no less frequently than every three years. The credentialing and recredentialed process shall include review of any information in the National Practitioners Databank. CCOs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialed Application. CCO's shall process all complete credentialing and recredentialed applications, including required documents, certificates, and licenses within the 90-day credentialing period;

(b) CCOs shall screen their 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;

(c) CCOs may elect to contract for or to delegate responsibility for the credentialing, recredentialed, and screening processes; however, CCOs shall be responsible for the following activities including oversight of the following processes, regardless of whether the activities are provided directly, contracted, or delegated:

(A) Ensuring 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) Providing training for CCO staff and participating providers and their staff regarding the delivery of coordinated care services, applicable administrative rules, and the CCOs administrative policies.

(d) The CCO 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 a CCO 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").
- (e) CCOs may not refer members to or use providers that:
 - (A) Have been terminated from the Division;
 - (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) CCOs may not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. CCOs shall recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination;
- (g) CCOs 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-Delivery System Network Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. CCOs 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.

~~(4) In accordance with ORS 414.646, A CCO may not discriminate with respect to participation in the CCO 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 a CCO 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 a CCO contract with any health care provider willing to abide by the terms and conditions for participation established by the CCO; or

(b) Preclude the CCO 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.~~

(c) If a CCO declines to include individual or groups of providers in its network, it shall, within the 90-day credentialing period, give the affected providers written notice of the reason for its decision. If there is no written response to the individual or groups of providers within the 90-day credentialing period, the affected providers may appeal to the CCO, provided the plan has an internal review process. It is the provider's option to use the CCO's discrimination review process. If the CCO does not have an internal discrimination review process or if the provider elects to not use the plan review process, the affected providers may appeal directly to OHA the Authority through the Provider Discrimination Review process.

(5) A CCO may establish an internal discrimination review process for a provider aggrieved by a decision under sections (4) through (6) of this rule, including an alternative dispute resolution. If unsatisfied with the CCO's written decision, providers may request an appeal of the decision through the plan's internal discrimination review process, provided the CCO has such a process.

(6) An aggrieved provider may appeal the determination of the CCO's internal discrimination decision to the Authority. The provider may ask the Authority to

reconsider the decision, even if the CCO does not have a provider discrimination review process, if the provider believes the CCO has discriminated against the provider on the basis of their licensure. To make such a request, the provider may submit form DMAP 2120, OHA Provider Discrimination Review Request.

~~(5) A CCO 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.~~

~~(67) To resolve discrimination appeals made to the Authority under sections (4) and ~~(5)~~ through (7) of this rule, the Authority shall provide administrative review of the provider's discrimination appeal using the administrative OHA Provider Discrimination Review Process review process established in OAR 410-120-1580. The Authority shall invite the aggrieved provider and the CCO to participate in the administrative Provider Discrimination Rreview. In making a determination of whether there has been discrimination, the Authority shall consider the CCO's:~~

(a) Network adequacy;

(b) Provider types and qualifications and credentialing qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(8) The Authority shall respond in writing to the individual or groups of providers. The written response shall occur within 100 days of the receipt by the Authority of the completed DMAP 2120 form or the receipt of any outstanding documentation needed to resolve the appeal, whichever is later.

~~(79) A-As specified in ORS 414.646, a prevailing party in an appeal under sections (4) through ~~(6)~~(7) of this rule shall be awarded the costs of the appeal.~~

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685