

**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 must 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.
- (3) CCOs must select providers using universal application and credentialing procedures and objective quality information. CCOs must take steps to remove providers from their provider network that 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 recredentialing 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 Recredentialing Application;
  - (b) CCOs must 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 and screening processes; however, CCOs shall be responsible for delegated activities, including oversight of the following processes:
    - (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 must 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 must 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 must recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction or termination;

(g) CCOs must require each atypical provider to be enrolled with the Authority and/or must 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. CCOs must require each qualified provider to have and use a National Provider Identifier 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), 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) 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 must 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 price.

(5) A CCO may establish an internal review process for a provider aggrieved by a decision under subsection (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.

(6) To resolve appeals made to the Authority under subsections (4) and (5) of this rule, the Authority will provide administrative review of the provider's appeal, using the administrative review process established in OAR 410-120-1580. The Authority will invite the aggrieved provider and the CCO to participate in the administrative review. In making a determination of whether there has been discrimination, the Authority must consider the CCO's:

(a) Network adequacy;

(b) Provider types and qualifications;

(c) Provider disciplines; and

(d) Provider reimbursement rates.

(7) A prevailing party in an appeal under subsections (4) through (6) of this rule shall be awarded the costs of the appeal.

Stat. Auth.: ORS 414.032

Stats. Implemented: 2011 HB 3650, Chapter 602, Oregon Laws 2011; 2012 SB 1580, Chapter 8, Oregon Laws 2012; 2012 SB 1509