

**MHO CONTRACTS & RULES WORKGROUP**  
**September 17, 2008**

**MHOs Attending:** Bruce Abel (LaneCare), Dave Bast (JBH), Kim Burgess (Washington Co), Kevin Campbell (GOBHI), Valerie Davis (ABHA), Susan Fillmore (FCI), Deborah Friedman (Clackamas MHO), David Hidalgo (Verity), Susan Montgomery (GOBHI), Joan Rice (Verity), Jim Russell (BCN)

**AMH Attending:** Tracey Robichaud, Kellie Skenandore, Ralph Summers

**Guest Appearance:** Linda Grimms, DOJ

Item	Discussion	Action
<p>1. Disclosure of Ownership – reporting requirement and forms</p>	<p>Linda Grimms provided background on the purpose of this requirement, which is to monitor providers sanctioned by the U.S. Department of Health and Human Services and ensure members are not referred to excluded providers. DHS/DOJ have developed 3 types of forms: Individual Performing Providers or Individuals in a Group of Practitioners; Entities, Agencies, Facilities and Organizations (private and public corporations); Governmental Agencies, Facilities and Organizations.</p> <p>Questions and discussion:</p> <ul style="list-style-type: none"> <li>▪ Governmental form is to be used both by plans that are governmental agencies (submit to AMH or DMAP) and by providers that are governmental agencies (submit to appropriate plan).</li> <li>▪ Plans can use the DHS forms or submit their own forms for approval.</li> <li>▪ The Oregon Practitioner Credentialing Application appears to meet the disclosure requirements for individual practitioners.</li> <li>▪ The corporate form is intended to reflect affiliations that have ownership relationships.</li> <li>▪ Do governmental entities have the equivalent of a Board of Directors that must be reported?</li> <li>▪ Non-profit BODs made up of community partners are not likely to meet the generally accepted standard of ownership, but those organizations should get legal advice on whether to list their BOD on the disclosure form.</li> <li>▪ Any provider/practitioner with an NPI and/or encounter data number will need to complete a form and submit it to DMAP and/or plans (potentially multiple plans).</li> </ul>	<ul style="list-style-type: none"> <li>▪ DHS will review the OPCA for compliance with the requirements</li> <li>▪ DHS policy decision</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Forms are to be maintained in credentialing files and be available for review.</li> <li>▪ DHS adding the forms to their credentialing process going forward; plans will be in compliance if they do the same.</li> </ul>	
<p>2. OAR 410-141-0120 – new language in 1(a)(C) and (D) and entirely new (E) and (F)</p>	<p>(C) New language “PHPs ... must provide accurate and timely information about license or certification expiration and renewal dates to DMAP. ...”</p> <p>Discussion:</p> <ul style="list-style-type: none"> <li>▪ The underlying requirement is that all providers must have valid licenses and/or certifications in order to receive Medicaid payment.</li> <li>▪ NPI on the encounter data submitted is the key to determining what licensure or certification information needs to be submitted.</li> <li>▪ If the NPI is the agency, then the agency certification information is to be submitted.</li> <li>▪ The obligation is on the provider to keep DMAP informed of licensure status.</li> <li>▪ As currently written, the OAR would result in double-reporting by plans and DMAP.</li> </ul> <p>Proposal: Revise the draft OAR language to require PHPs to submit licensure expiration and renewal dates for encounter-only providers, and to include a reference to the Oregon Practitioner Credentialing Application meeting the criteria for disclosure of ownership (assuming that is the finding of the DHS review).</p>	<p>Deborah will draft language for submission to Tom Vanderveen.</p>
<p>3. Conflict of Interest</p>	<p>Linda provided consultation on the intent of the language in section E (or 5, depending on which version of the language is being used). The first sentence requires that plans have policies and procedures relating to conflict of interest. The second sentence and (i) and (ii) provide specific safeguards related to the DHS procurement process.</p> <p>Proposal: It was suggested that the second sentence be revised to include a reference that the safeguards relate to the DHS procurement process. A draft contract with the current language has been sent to CMS for review. CMS may not be willing to consider a replacement page with the proposed revision.</p>	<p>Linda will take the proposal to Ted Falk for consideration.</p> <p>AMH will inform the MHOs regarding CMS' willingness to consider a revision</p>

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<p>4. Long Term Care Schedule 2.1</p>	<p>The first version of the LTC revisions included changes in criteria for finding client eligible for LTC. That language has been removed from the current revisions. Version 2 includes only housekeeping changes. Those changes are in the draft contract sent to CMS.</p> <p>The plans expressed concern about any change in criteria that restricts eligibility for LTC. It was requested that the MHOs be included in any policy discussion about a change in criteria for LTC. It was suggested that that discussion occur at the MHO Contractor meeting.</p>	<p>AMH agrees the policy discussion would include MHOs among other stakeholders.</p>
<p>5. Hospital reimbursement</p>	<p>Kim updated the group on discussions at the Acute Care Leadership group regarding MHO reimbursement for inpatient services. At the most recent meeting of the group it was noted that the AMH "cost of care" policy does NOT apply to MHOs. The discussion was reframed by Kevin Earls of OAHHS as a contracting issue. OAHHS is seeking assurance that the MHOs are required to have contracts with hospitals; the perception is that MHOs are avoiding contracting with hospitals.</p>	<p>AMH is conducting a study to determine what percentage of hospital claims are paid to par and non-par hospitals by MHOs. AMH will share the results of this study with MHOs prior to any public distribution.</p>

**Next meeting:**

**Agenda:**