AdvancedHealth
Bridging the Future of Healthcare
289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400 | Toll Free: 800-264-0014
TTY: 800-264-0014

NOTICE
~Additional Information Required~

From: Advanced Health
Provider Enrollment

Phone: 541-269-7400
Fax: 541-266-0141

Dear Medical Services Provider:

We have received a claim on your behalf and have found that the facility and/or attending provider are currently not recognized in the State of Oregon's Medicaid System as a performing provider and we are unable to submit the claim to the State's Medicaid system.

In order for Advanced health to be able to process the claim, you will need to complete the application on the included with this letter and fax it and a copy of your claim to Advanced Health at 541-266-0141. In turn, Advanced Health will submit the application to the State Medicaid office to request that a performing provider ID number (DMAP number) be issued. Please note that it can take up to 45-60 days for the State to issue an ID number once your application is received. *Your cooperation in returning your application and claim in a timely manner is greatly appreciated.*

Notice: *The State of Oregon, Oregon Health Authority (OHA,) requires all health care providers and suppliers to submit both Social Security Numbers and Date of Birth information when initially enrolling or revalidating their participation with an Oregon Coordinated Care Plan. OHA is taking this action as required under Section 6401 of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010. The CMS final rule addressing Section 6401 of the PPACA is CMS-6028-FC.*

Please complete the application and send it, along with a copy of your claim and a W-9 to Advanced Health using one of the following methods:

Fax to:
Advanced Health
Attn: Provider Enrollment
Fax: 541-266-0141

Mail it to:
Advanced Health
Provider Enrollment
289 Laclair Street
Coos Bay, OR 97420
Secure Email it to: emilie.wilson@advancedhealth.com

Thank you for your assistance to ensure Oregon Medicaid funds are used as efficiently as possible for our covered members. Feel free to contact us with any questions.

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Bridging the Future of Healthcare
289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400 | Toll Free: 800-264-0014
TTY: 800-264-0014

Oregon Medicaid - Provider Application

1 Last Name	First Name	MI	Gender	2 Business Name (if different)	
3 Physical Service Address				4 Billing Address (if different)	
City	State	Zip		City State Zip	
5 Billing Contact Area Code and Phone #				6 Billing Contact Email Address	
7 Organization (W-9 Required) ☐ Corporation ☐ Sole Proprietor ☐ Tribal ☐ Partnership ☐ Government Owned ☐ Not for Profit ***(IRS Affirmation Letter Required)***				8 State Licensing Board 10 License Effective Date	9 State License Number 11 License Expiration Date
12 Provider Type	13 Specialty Type			14 Requested DMAP Effective Date	
15 NPI #				16 Taxonomy Code(s)	

17 Required Identification Number Type:

(Medical Provider) ☐ Provider's Full Name: _____
First MI Last

(HOSPITAL Only) ☐ Hospital Administrator' Full Name: _____
First MI Last

(Ancillary Provider) ☐ Owner/Administrators Name: _____
First MI Last

☐ Social Security Number of individual above: _____

☐ Date of Birth of individual above: _____

22 Business Tax Identification Number (FEIN)	23 Business NPI

Fax completed application, claim & W-9 back to: Advanced Health, Attn: Provider Enrollment. at 541-266-0141.

*****For Office Use Only*****		
ATN	ATN Entry Date	Notes:
Enrolled From/To	DMAP #	
Provider #	Vendor #	

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Provider Disclosure Statement of Ownership and Control, Business Transactions and Criminal Convictions

Purpose

Federal law requires fiscal agents, managed care entities (MCEs), and other Oregon Medicaid providers, including applicants and certain bidders seeking to provide Oregon Medicaid services, to disclose all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

Instructions

For these disclosures, the Oregon Health Authority (OHA) requires fiscal agents, MCEs, and other providers to complete this form entirely.

Submit tax identification numbers (TINs) for all individuals or entities reported using this form. Submit a Social Security number (SSN) for all individuals, and Employer Identification number (EIN) for all entities.

OHA requires SSNs in order to conduct the provider screenings required by 42 CFR § 455 Subpart E. See 42 U.S.C. § 1320a-3, 42 U.S.C. § 405 (c)(1) and OHA's Privacy Policy and Disclosure Notice *(page 1 of the Information and Instructions at the end of this form)* to learn more about this requirement.

For questions about filling out this form, see the Information and Instructions (after page 5 of this form). Form will not be accepted if missing information such as TIN or DOB. Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to enroll or contract, or if the Provider already is enrolled, termination of its agreement or contract.

Please check each box that explains the reason for disclosure:

☐ New enrollment ☐ Reactivated enrollment ☐ Revalidation

☐ Change in ownership ☐ Change in managing employees

Contact name:
Contact phone:
Contact email:

Provider NPI #:

Section I. Disclosing entity information

Legal name of provider *(individual, agency, facility or group)*:	
Doing Business As (DBA):	
TIN *(SSN for individual, EIN for entity)*:	**Service address:**
National Provider Identifier (NPI):	

Section II. Disclosure information

In this section, please report the following information:

Owner (5% or more):
List the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. For individuals, include DOB and SSN; for corporations, include TIN.

Subcontractor:
List all subcontractors who are related to the disclosing entity owners as a spouse, parent, child or sibling, where the disclosing entity has a 5% or more interest in the subcontractor.

Managing employee:
List the name, address, DOB and SSN of any managing employee of the disclosing entity.

Other interest:
List the name of any other disclosing entity or fiscal agent or managed care entity in which the owner of the disclosing entity has an ownership or control interest; or of any other individual or entity with other interest. Other interest in the provider can be:

- The owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;
- An officer or director of the entity, if the entity is organized as a corporation; or
- Partner in the entity, if the entity is organized as a partnership.

Sanctions, exclusions or convictions:
Indicate whether the individual or entity reported on this form has experienced any of the following:

- **Sanction or exclusion** from participation in Medicare or any state health care programs;
- **Conviction** for a criminal offense or assessed civil penalties related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs, or as described in sections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act; **or**
- Transfer of their ownership or control interest to an immediate family member or a member of the person's household, in anticipation of or following any of these events.

Provider NPI #:

Disclosure # 1	
Person type. *Who is this disclosure for? Check one:* ☐ Individual ☐ Corporation	
Disclosure type. *Check all that apply:* ☐ Owner (5% or more) ☐ Subcontractor ☐ Managing employee ☐ Other interest	
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? *Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Additional Disclosures (make copies as needed)	
Person type. *Who is this disclosure for? Check one:*	
☐ Individual	☐ Corporation
Disclosure type. *Check all that apply:*	
☐ Owner (5% or more)	☐ Subcontractor
☐ Managing employee	☐ Other interest
Name	**Address** *(If corporate, list primary business address and PO Box if applicable)*
TIN *(SSN for individual, EIN for corporation)*	
Date of birth	

Sanctions, exclusions or convictions (42 CFR §455.100)

Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program? **Must select Yes or No. If Yes, check all that apply:* ☐ Yes ☐ No

☐ Sanctioned ☐ Excluded ☐ Convicted

Describe the reason for the sanction, exclusion, or conviction:

Has this person transferred their ownership to a family or household member in anticipation of being sanctioned, excluded or convicted? ☐ Yes ☐ No

Relationships

Is this person related to anyone with ownership or control interest in the entity? ☐ Yes ☐ No

If yes, list the name of each person, followed by that person's relationship to the entity (e.g., spouse, parent, child, sibling). *Attach separate sheet if necessary*.

Name	**Relationship**

Other ownership or control interest

Does this person have ownership or control interest in any other entity? ☐ Yes ☐ No

If yes, list the names of the other entities. *Attach separate sheet if necessary.*

Provider NPI #:

Section III. Business transactions: Only complete at the request of CMS or OHA

During the last 12-month period, has this entity had business transactions totaling more than $25,000 with a subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

During the last five years, has this entity had significant business transactions with any wholly owned supplier or subcontractor? ☐ Yes ☐ No

If yes, list the name, address and TIN for the supplier or subcontractor; and the owner(s) names and addresses. *Attach separate sheet if necessary.*

Section IV. Disclosing entity's attestation, signature, and date

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that by knowingly providing false information on this form or in connection with any claim for payment from the State of Oregon, which may include federal funds, I may be liable for a false claim under the Oregon False Claims Act (ORS 180.750 to 180.785) and the federal False Claims Act (31 USC 3279 to 3733). I agree to inform OHA or its designee, in writing, within 30 days of any changes or if additional information becomes available.

Name of authorized representative

Title

Signature

Date

3974 Form Information and Instructions

Do not fax these pages to OHA. Only fax pages 1 through 5 of this form.

Privacy Policy and Disclosure Notice

This privacy policy and disclosure notice explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security numbers (SSNs) and Dates of Birth, may be requested and used in connection with Provider enrollment and the administration of OHA medical assistance programs.

- Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the program.
- Any information may also be provided to the Oregon Secretary of State, the Oregon Department of Justice including the Medicaid Fraud Unit, or other state or local agencies as appropriate, the Internal Revenue Service, U.S. DHHS Centers for Medicare and Medicaid Services or Office of the Inspector General, or other authorized federal authority. Disclosures for other purposes must be authorized by law. For more information about access to information maintained by OHA, contact the Provider Services Unit.

The Authority limits its request for and use of taxpayer identification numbers, including SSNs and DOBs, to those purposes authorized by law and as described in this notice. The Oregon Consumer Identity Theft Protection Act permits OHA to collect and use SSNs to the extent authorized by federal or state law.

Providers must submit the provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, whichever is required for tax reporting purposes on an IRS Form 1099.

Billing providers must submit the performing provider's SSN (for individuals) or a federal employer identification number (EIN) for entities or other federal taxpayer identification number, in connection with payments made to or on behalf of the performing provider.

Providing this number is mandatory to be eligible to enroll as a provider with the Authority, pursuant to 42 CFR 433.37, the federal tax laws at 26 USC 6041, and OAR 407-120-0320,410-120-1260(9)(a)(B)(i)(V) and 410-141-0120 for purposes of the administration of tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities.

Taxpayer identification numbers for the provider, and individuals or entities other than the provider, are also subject to mandatory disclosure for purposes of the Disclosure of Ownership and Control Interest Statement, as authorized by OAR 407-120-0320(5)(A)(c), 410-120-1260, 410-120-1510(M), 410-120-1380(1)(M) and OAR 410-141-0120.

Failure to submit the requested taxpayer identification number(s) may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from OHA or for encounter purposes.

Definitions

Definitions for the terms that are used in this form are provided here for your convenience.

A. The source of these definitions is 42 CFR § 455.101:

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs[1], as defined by 42 CFR §455.101.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. This includes:

- An officer or director of the disclosing entity, if the entity is organized as a corporation;
- Partner in the disclosing entity, if the entity is organized as a partnership.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes

(a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
(b) any Medicare intermediary or carrier; and
(c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

[1] The following terms are defined in 42 CFR 438.2.

- Health Insuring Organization (HIO)
- Prepaid Inpatient Health Plan (PIHP)
- Managed Care Organization (MCO)
- Primary Care Case Manager (PCCM)
- Prepaid Ambulatory Health Plan (PAHP)

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

(a) has an ownership interest totaling five percent or more in a disclosing entity;
(b) has an indirect ownership interest equal to five percent or more in a disclosing entity;
(c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;
(d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;
(e) is an officer or director of a disclosing entity that is organized as a corporation; or
(f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

Subcontractor means

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Relationships to excluded, penalized, or convicted persons in accordance with 42 CFR §1002.3

The following terms are as defined in 42 CFR §1001.2:

- **Immediate family member** means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- **Member of household** means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Instructions for determination of ownership or control percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. The source of these definitions is 42 CFR § 455.102.

A. Indirect ownership interest

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation, which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

Person with an ownership or control interest.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Instructions for disclosing entity's signature

Signature and date stamps, or the signature of anyone other than the provider/fiscal agent, applicant, bidder, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.

Print Save Reset

HEALTH SYSTEMS DIVISION
Provider Enrollment Unit

Oregon Health Authority

Provider Enrollment Agreement

The Oregon Health Authority (OHA) administers Oregon's medical assistance program for individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other federally funded medical programs, called the Oregon Health Plan (OHP). To comply with Federal law 42 CFR 455 Subpart E, OHA is required to enroll eligible providers into the Oregon Medicaid Program, pursuant to Oregon Administrative Rule 943-120 and 410-120, as a condition of delivering health services to OHP members.

All providers including non-payable (non-billing), payable (billing), individuals and organizations must fill out and sign this Agreement and all other required documents to receive an OHP provider number from OHA. An OHP provider number must be issued before a claim or encounter for delivered health services or goods is sent to OHA for payment.

The type of providers enrolled by OHA are defined in OAR 410-120-1260 and include billing agents, managed care entities (MCEs) and other providers who order, refer or prescribe services or goods.

Provider name _____ National Provider Identifier (NPI) _____

Scope of Agreement

This Provider Enrollment Agreement sets forth the rights, responsibilities, terms and conditions governing provider participation in the Oregon Medicaid program. Per OAR 410-120-1260(17), the provision of health care services or items to OHP clients is a voluntary action on the part of the provider. Providers are not required to serve all Division clients seeking service.

To be eligible for enrollment, a provider must:

A. Complete and submit an Enrollment Application
B. Agree to and sign this Provider Enrollment Agreement (Agreement)
C. Complete, sign and submit a Medicaid Provider Disclosure Statement (organizations and billing providers only)

D. Be an eligible provider and meet the conditions in (OAR) 410-120-1260 and any rules directly related to the provider's service category and OHA program in effect on the date of enrollment, and,
E. Meet all the applicable state and/or federal licensure or certification requirements to assure OHA provider meets minimum qualifications to perform services under this Agreement. This includes maintaining a professional license or certification in good standing and compliance with all program rules and rules related to providers service category.
F. Pass all mandatory screening and validation steps.
G. This Agreement becomes effective the date approved by OHA for date requested on initial application.
H. For revalidation and any other circumstances, this Agreement becomes effective the date signed by Provider.
I. Failure to comply with the terms of this Agreement or any applicable CFR or OAR may result in termination, sanction(s) or payment recovery, subject to Provider appeal rights, pursuant to OHA rules.

Governance

Oregon's Medicaid program is authorized and governed by:

- Title XIX of the Social Security Act
- Title XXI of the Social Security Act
- Chapter IV and V of Title 42 of the Code of Federal Regulations (CFR);
- Oregon Revised Statue (ORS) 414;

This Agreement is governed by federal law pertaining to the Medicaid program and the laws of Oregon that include: OAR Chapters 410, 943 and any OAR applicable to provider's service category, e.g. Mental Health.

OHA's administrative rules are posted and available at all times on OHA's website and Oregon's Secretary of State (SOS) website. Federal regulations are posted and available at all times on Electronic Code of Federal Regulations (eCFR) and Federal Register websites. It is the provider's responsibility to become familiar with and abide by these rules.

Assurances

As an OHP provider, hereafter known as "Provider," and as a condition of payment for goods or services under this Agreement, you agree to:

Comply with applicable laws

A. Comply fully with all federal, state and local laws, rules, regulations, and statements of OHA policy applicable to the care, services, equipment or supplies including but not limited to OAR 410-120-1380, and this Agreement. Failure to comply with the terms of this Agreement or OHA

rules may result in sanction(s) and/or payment recovery, which may also result in termination pursuant to federal regulation, OHA rule, and any contract(s) between the Provider and OHA.

B. Provider shall at all times be qualified, professionally competent and actively licensed where required by law to perform work under this Agreement.

Disclosure

Provider understands and agrees that:

A. The information in the enrollment form(s) and all supporting documentation is true, accurate and complete. Information disclosed by a Provider is subject to verification. OHA will use this information for administration of the Oregon Medicaid program.

B. Loss, suspension or restriction of licensure, or certification, may result in immediate disenrollment.

C. Any deliberate omission, misrepresentation or falsification of information in enrollment form(s) or in any communication supplying information to OHA may be prosecuted under state or federal law.

D. All providers that request to enroll or are already enrolled are subject to additional screening by OHA at any time. Additional screening includes, but is not limited to, pre and post enrollment site visits and fingerprint and criminal background check.

E. Provider is not excluded or otherwise prohibited from participating in Medicare or any state Medicaid or CHIP programs. Provider has not been convicted of a criminal offense related to Medicare, Medicaid, CHIP or any federal agency or program.

F. Provider is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Non-procurement Programs" currently found at https://www.sam.gov/portal/public/SAM/. Provider will not use public funds to support, in whole or in part, the employment of individuals in any capacity having contact with Medicaid eligible individuals who have been convicted of a crime as identified under ORS 443.004(3), are on the Office of Inspector General (OIG) list of excluded individuals or entities, on the System Award Management (SAM) exclusion list, or the Data Exchange (DEX).

Services

Provider understands and agrees that:

A. The Provider agrees that all health care, services, equipment or supplies billed to Medicaid must be medically necessary, a covered service as defined in OAR Chapter 410, and provided in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services or items under OHP in effect on the date of service. Rules for OHP services are listed in OAR 410-120-1160 and defined in OAR Chapter 410 and Chapter 309. Provider further agrees to:

   a. Provide services within the parameters permitted by the Provider's license or certification and agrees to bill only for the services performed within the specialty or specialties designated in the Provider application on file OAR 410-120-1260. The

services of goods must have been actually provided to the OHP member by the Provider prior to submitting a claim or encounter to OHA.

b. Provide all services under this Agreement as an independent contractor. Provider is not an "officer," "employee" or "agent" of OHA, as the term is used in ORS 30.265.

B. Provider is responsible for verification of client OHP eligibility and benefit coverage and following applicable prior authorization requirements before rendering services as required in OHA Rules and described in OAR 410-120-1140.

Recordkeeping and access to records

Provider understands and agrees to:

A. Keep such records as are necessary to fully disclose the specific care, services, equipment or supplies provided to OHP members for which reimbursement is claimed, at the time it is provided, in compliance with the applicable OHA rules and federal regulations in effect on the date of service. Provider is responsible for the completeness, accuracy and secure storage of financial and clinical records and all other documentation of the specific care, services, equipment or supplies for which the provider has requested payment as required by OAR 410-120-1360 and any program specific rules in OAR Chapter 410 and Chapter 309.

B. Provide upon request by either OHA, the Program Integrity Audit Unit (PIAU), the Office of Payment Accuracy and Recovery (OPAR), the Oregon Secretary of State's Office, Federal Government, and the Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU), or any duly authorized representatives, immediate access to review and make copies of any and all records relied on by Provider in support of care, services, equipment or supplies billed to the Oregon medical assistance program. The term "immediate access" means access to records at the time the written request is presented to the Provider.

Communication

Provider understands and agrees that:

Any communication or notices from the Provider shall be given in writing via personal delivery, fax, email or regular mail, postage prepaid to OHA. Provider must notify OHA of any changes to Provider’s information such as, address, name, licensure, within 30 days of the date of the change.

Provider enrollment forms should be faxed with an EDMS Coversheet to 503-378-3074.

Email communications should be sent to Provider.Enrollment@dhsoha.state.or.us.

General information regarding Provider’s enrollment record should be faxed to 503-947-1177.

Confidentiality

Provider understands and agrees to:

Comply with the Health Insurance Portability and Accountability Act (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, and federal regulations at 45 CFR Parts 160 and 164, and as amended. The Provider specifically acknowledges their obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations. Provider agrees to comply with requirements for identifying, addressing and reporting an incident or breach, regardless of whether the incident or breach was accidental or otherwise.

Security

Provider understands and agrees that:

The Provider represents and warrants that the Provider will establish and maintain privacy and security standards and practices that respect and safeguard the privacy and security of all information related to OHA and the agency's employees, equipment, providers, systems and service recipients, regardless of media. Provider shall ensure the proper handling, storage and disposal of all information accessed, created, obtained, reproduced, or stored by the Provider and its authorized users using privacy and security standards that meet or exceed standards set by laws, rules, and regulations in (HIPAA) §262 and 264 of Public Law 104-191, 42 USC §1320d, OAR Ch 943, the Oregon Consumer Identity Theft Protection Act, ORS 646A.600 through 646A.628, and Oregon's Statewide Information Security Standards, applicable to the information exchanged by the Provider and OHA or received by the Provider as a servicer of this Agreement. Provider shall ensure proper disposal of equipment and information assets when authorized use ends, consistent with Provider's record retention obligations and obligations regarding information assets under this Agreement.

Accurate billing

Provider understands and agrees that:

A. All claims or encounters submitted to OHA must be certified by signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the care, service, equipment or supplies claimed were actually provided, medically appropriate, documented at the time they were provided, documented using required diagnosis (ICD-10-CM) and procedure codes (HIPAA), and were provided in accordance with professionally recognized standards of health care, OAR 410-120-1280 through 1340 and this Agreement.
B. The Provider or its contracted agency, including billing providers, shall not submit or cause to be submitted:
    a. Any false claim for payment;
    b. Any claim altered in such a way as to result in a payment for service that has already been paid;
    c. Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed with the exceptions described in OAR

410-120-1280. If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to OHA. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPL Explanation Code; or

d. Any claim for furnishing specific care, items, or services that has not been provided.

C. The Provider is responsible for the accuracy of claims submitted, and the use of a billing entity does not change the Provider's responsibility for the claims or encounters submitted on Provider's behalf. OHA may recover any overpayment(s) that OHA made to Provider, by withholding future payment(s) or other processes as authorized by law or Agreement. If Provider fails to correct billing practices after written notice by OHA of non-compliance with state rules will be liable for up to triple the amount of identified overpayment(s).

Payment

Provider understands and agrees that:

A. Provider will accept OHA's payment as complete remuneration the amount paid in accordance with the reimbursement rate for services covered under OHP, except where payment by the client is authorized in the OARs. Payment will only be made to the enrolled provider who actually performs the service or to the Provider's enrolled billing provider for covered services rendered to eligible clients, OAR 410-120-1340.

B. OHA has sufficient funds currently available and authorized to make payments under this Agreement within OHA's biennial budget. Provider further understands and agrees that payment for services performed after the current biennium is contingent on OHA receiving from the Oregon Legislature appropriations or other expenditure authority sufficient to allow OHA, in its reasonable administrative discretion, to continue to make payments.

C. Provider must not bill OHP members for any services unless authorized by Oregon Administrative Rule.

D. Any overpayment made to Provider by OHA may be recouped by OHA as authorized by law including, but not limited to withholding of future payment to Provider. Provider's failure to perform the work specific in the Agreement or to meet the performance standards established in this Agreement, may result in consequences that include, but are not limited to reducing or withholding payment; requiring Provider to perform at Provider's expense additional work necessary to meet performance standards; and pursuing any available remedies for default including termination of this Agreement.

E. Provider is not an officer, employee or agent of OHA and shall not be deemed for any purpose an employee of the State of Oregon. The Provider shall perform all work as an independent contractor, as defined in ORS 670.600, and is responsible for determining the appropriate means and manner of performance. Provider is responsible for all federal and state taxes applicable to compensation paid to Provider under this Agreement and, unless Provider is subject to backup withholdings, OHA may withhold from such compensation any amounts to cover Provider's federal or state tax obligations. Provider has no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State

of Oregon or federal agency would prohibit Provider's work under this Agreement. Provider certifies it is not currently employed by the federal government.

F. OHA and Provider are the only parties to this Agreement and are the only parties entitled to enforce its terms. The parties agree that Provider's performance under this Agreement is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Agreement gives or shall be construed to give or provide any benefit or right, whether directly or indirectly to third persons that are any greater than the rights and benefits enjoyed by the general public.

G. As a condition of payment, Provider must meet and maintain compliance with the Provider enrollment and payment rules OAR chapter 410, division 120; 42 CFR 455.400 through 455.470, as applicable; and 42 CFR 455.100 through 455.106.

Discrimination

Provider understands and agrees to:

A. Comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.

B. Not discriminate against minorities, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts.

C. Provide services to Medicaid-eligible individuals without regard to race, religion, national origin, sex, age, marital status, sexual orientation or disability (as defined under the Americans with Disabilities Act). Medicaid services must reasonably accommodate the cultural, language and other special needs of the member.

Compliance with applicable laws

Provider understands and agrees that:

A. Provider shall comply and require all subcontractors to comply with federal, state and local laws and regulations, executive orders and ordinances applicable to items and services under this Agreement, including but not limited to OAR 407-120-0325, as they are amended from time to time. Without limiting the generality of the prior sentence, the Provider expressly agrees to comply and require all subcontractors to comply with all of the laws, regulations and executive orders listed under OAR 410-120-1380 to the extent they are applicable to the items and services provided under this Agreement.

B. Provider agrees that if any term or provision of this Agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected and the right and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

Duration and termination of Agreement

Provider understands and agrees that:

A. This Agreement shall remain in effect for no more than five years from the effective date. OHA may terminate this Agreement at any time by written notice to the Provider by certified mail, return receipt requested, subject to any specific provider sanction requirements in OHA rules or Agreement(s) between OHA and the Provider.

B. OHA will terminate or suspend this Agreement if:
   a. The Provider or a person with 5 percent or greater direct or indirect ownership interest in the Provider, its agent or managing employee fails to submit timely, complete and accurate information, or cooperate with any screening requirements, unless OHA determines it is not in the best interests of the Medicaid program;
   b. Any person with a 5 percent or greater direct or indirect ownership interest in the Provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or title XXI program in the last 10 years, unless OHA determines it is not in the best interests of the Medicaid program;
   c. The Provider is terminated under title XVIII of the Social Security Act or under the Medicaid program or Children's Health Insurance Plan (CHIP) program of any state;
   d. The Provider or any person with a 5 percent or greater, direct or indirect, ownership interest in the Provider fails to submit sets of fingerprints in a form and manner to be determined by OHA within 30 days of a Centers for Medicare and Medicaid Services (CMS) or a OHA request, unless OHA determines it is not in the best interests of the Medicaid program;
   e. The Provider fails to permit access to Provider locations for any site visits under 42 CFR 455.432, unless OHA determines it is not in the best interests of the Medicaid program;
   f. CMS or OHA determines that the Provider has falsified any information provided on the application or if CMS or OHA cannot verify the identity of the Provider applicant.
   g. OHA fails to receive funding, appropriations, limitations or other expenditure authority at levels that OHA or the specific program determines to be sufficient to pay for the services or items covered under this Agreement;
   h. Federal or state laws, regulations or guidelines are modified, or interpreted by OHA in a manner that either providing the services or items under the Agreement is prohibited or OHA is prohibited from paying for such services or items from the planned funding source;
   i. OHA issues a final order revoking this Agreement based on a sanction under termination terms and conditions established in program-specific rules or policies, if required;
   j. The Provider no longer holds a required license, certificate or other authority to qualify as a Provider. The termination will be effective on the date the license, certificate or other authority is no longer valid;
   k. The Provider fails to meet one or more of the requirements governing participation as a OHA enrolled Provider. In addition to termination or suspension of the

Agreement the Provider number may be immediately suspended in accordance with OAR 407-120-0360;

I. Provider commits any material breach or default of any covenant, warranty, or obligation under this Agreement, fails to perform the work under this Agreement or fails to pursue the work as to endanger Provider's performance under this Agreement in accordance with its terms;

C. Provider may terminate this Agreement at any time, subject to specific Provider termination requirements in OHA rules, OHA program-specific rules or federal regulations by submitting a written notice, in person, or by certified mail listing a specific termination effective date. The request must be in writing and signed by the provider. The notice shall specify the OHA-assigned provider number to be terminated and the effective date of termination. Termination of this Agreement does not relieve the Provider of any obligations for covered services or items provided for the dates of services during which the Agreement was in effect.

Insurance requirements

Required insurance: During the term of this Agreement, Provider shall possess any and all insurance required within the program rules based on Provider type and any business requirements set forth by the Department of Consumer and Business Services at Providers cost and expense. The insurance may include, but is not limited to, general liability, professional liability, malpractice, workers compensation, employer's liability, excess/umbrella insurance, tail coverage, etc. Provider must retain any and all certificate(s) and proof of insurance, notice of change or cancellation, insurance reviews, state acceptance or other actions on the providers insurance.

Upon request, Provider will provide to OHA not more than thirty (30) days of any change, reduction, suspension, cancellation or termination of Provider's insurance coverage required by this section.

OHA may exempt Provider from these requirements for any reason, including but not limited to the inability of Provider to procure such insurance.

Indemnification

Provider shall defend (subject to ORS Chapter 180), save, hold harmless, and indemnify the State of Oregon and OHA and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever, including attorney fees, resulting from, arising out of, or relating to the activities or omissions of Provider or its officers, employees, subcontractors, or agents under this agreement.

Provider: I have read the foregoing Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for other sanctions as provided by statute, administrative rule, or this Agreement.

Provider or authorized signature

I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Oregon Medicaid Program and/or prosecution for Medicaid fraud. I certify that I have read and understand the federal and state laws rules and regulations as cited in this Agreement. I agree to abide by the Oregon Medicaid Program terms and conditions listed in this document and aforementioned regulations.

Print name of Provider or authorized official	Title of authorized official *(if applicable)*
Signature of Provider or authorized official	Date

Site Visit and Fingerprint Criminal Background Check
CCO Enrollment Summary revised 3/2023

Requirements

- CFR 455.432 requires the state to conduct pre-enrollment and post-enrollment (revalidation) site visits for Moderate and High-risk provider types.
- CFR 455.434 requires the state to conduct criminal background checks on persons with a 5% or greater ownership interest in the provider categorized as high risk.
- The State may rely on Medicare screening activities if data elements match

ATN/3108 Additional Requirements but not limited to:

- **Service Location Address on ATN must match service location**
- **Phone number of person to contact at provider office service location.**

Risk Categories

Moderate Risk Providers – Site Visit required prior to enrollment

- Ambulance service suppliers
  - Type 01, Specialty 025
- Community mental health centers
  - Type 33, Specialty 092, 207
  - Type 33, Specialty opioid treatment (coming once there is a specific specialty)
- Hospice organizations
  - Type 27
- Independent clinical laboratories
  - Type 29
- Physical therapists enrolling as individuals or as a group
  - Type 45, Specialty 420 **** See additional Information required below**
  - Type 09, Specialty 054
- Portable x-ray suppliers
  - Type 52
- Revalidating Home Health agencies
  - Type 24
- Revalidating DME suppliers
  - Type 36
- National Diabetes Prevention Program Supplier (March 2023)
  - Type 63

High Risk Providers – Site Visit and FCBC required for owners prior to enrollment

- Newly enrolling Home Health agencies Type 24
- Newly enrolling DME suppliers Type 36

CCO Activities
Please inform your enrolling Moderate and High-risk providers of the requirements and inform them the State may be contacting them to perform such functions.

Miscellaneous

- Comprehensive outpatient rehabilitation facilities (CORF)
- Independent diagnostic testing facilities (IDTF)

The State is currently working with CMS to identify and build an appropriate enrollment process for the CORF and IDTF providers. Once completed the CCO's will be provided updated information.

****Additional information required for provider type 45 with specialty 420 physical therapy for site visits**

- ☐ Therapist (45)
  - ☐ Occupational
  - ☐ Physical ***(see question below)***
  - ☐ Speech/language pathologist
  - ☐ Audio / speech
  - ☐ Audiologist
  - ☐ Speech / hearing therapist

Physical therapists only: Do you provide services exclusively in a patient's home, provider's personal home, institutional setting, or a school?

☐ Yes ☐ No

Group affiliation [redacted] *Please note that group affiliation(s) have no impact on claims*

Primary organization name:			
Organization NPI:		Organization Medicaid ID:	
Organization tax ID:			