OREGON HEALTH PLAN

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # 139071

with

Tri-County Medicaid Collaborative

Table of Contents

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OREGON HEALTH PLAN

HEALTH PLAN SERVICES CONTRACT

COORDINATED CARE ORGANIZATION

This Health Plan Services Contract, Coordinated Care Organization Contract # ((XXXXXX)) ("Contract") is between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA", and

Tri-County Medicaid Collaborative
315 SW 5th Avenue, Suite 900
Portland, Oregon 97204

hereinafter referred to as "Contractor." OHA and Contractor are referred to as the "Parties".

Work to be performed under this Contract relates principally to the following Divisions of OHA:

Division of Medical Assistance Programs (DMAP)
500 Summer Street NE, E35
Salem, Oregon 97301

and

Addictions and Mental Health Division (AMH)
500 Summer Street NE, E86
Salem, Oregon 97301

I. Effective Date and Duration

A. This Contract is effective on the first of the month after the last to occur of:

1. September 1, 2012,

2. Approval by the Department of Justice and by CMS, or

3. The date specified in OHA's Notice to Proceed, which OHA will issue to Contractor after Contractor has satisfied the conditions OHA has specified for Contractor's readiness review.

B. Unless extended or terminated earlier in accordance with its terms, this Contract expires on December 31, 2013.

Contractor shall notify OHA not less than 90 days before the expiration date of its intent to not proceed with a renewal contract.

II. Contract in its Entirety

This Contract consists of this document together with the following exhibits and schedules (some of which in turn have attachments), which are attached hereto and incorporated into this Contract by this reference:

Exhibit A: Definitions
Exhibit B: Statement of Work
Exhibit C: Consideration
Exhibit D: Standard Terms and Conditions
Exhibit E: Required Federal Terms and Conditions
Exhibit F: Insurance Requirements
Exhibit G: DSN Provider and Hospital Adequacy Report Reporting Requirements
Exhibit H: Practitioner Incentive Plan Regulation Guidance
Exhibit I: Grievance System
Exhibit J: Readiness Review
Exhibit K: Transformation Plan
Exhibit L: Solvency Plan and Financial Reporting
Exhibit M: Benefits and Covered Services for MHO Members

There are no other Contract documents unless specifically referenced and incorporated in this Contract.

III. Vendor or Sub-Recipient Determination

In accordance with the State Controller's Oregon Accounting Manual, policy 30.40.00.102, and OHA procedure "Contractual Governance," OHA determines that:

☐ Contractor is a sub-recipient; OR ☒ Contractor is a vendor.

Catalog of Federal Domestic Assistance (CFDA) #(s) of federal funds to be paid through this Contract: CFDA 93.767 and CFDA 93.778

IV. Status of Contractor

A. Contractor is a domestic non-profit corporation organized under the laws of Oregon.

B. Contractor designates:

Janet Meyer
315 SW 5th Avenue, Suite 900
Portland, Oregon 97204
Phone: 503-449-3698
Fax: 503-416-1798
Email: janet@tricountycollaborative.org

as the point of contact pursuant to Exhibit D, Section 23 of this Contract. Contractor shall notify OHA in writing of any changes to the designated contact.

V. Enrollment Limits and Service Area

A. Contractor's maximum Enrollment limit by Service Area is:

50,100	Clackamas County
145,200	Multnomah County
73,150	Washington County

B. Contractor's maximum Enrollment limit is: 268,450. The maximum Enrollment limit established in this section is expressly subject to such additional Enrollment as may be authorized in Exhibit B, Part 3, Section 5, of this Contract; however, such additional authorized Enrollment does not create a new maximum Enrollment limit.

VI. Interpretation and Administration of Contract

B. OHA has adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract. Contractor shall abide by all laws and Oregon Administrative Rules (OARs) applicable to Contractor's performance under this Contract, including but not limited to the CCO Administrative Rules.

C. In interpreting this Contract, the Parties shall construe its terms and conditions as much as possible to be complementary, giving preference to this Contract (without exhibits, schedules or attachments) over any exhibits schedules or attachments. In the event of any conflict between the terms and conditions of Exhibit C, Attachment 2, and any other exhibit, schedule or attachment, Exhibit C, Attachment 2, controls. In the event of any conflict between the terms and conditions in any other exhibits, schedules or attachments, the document earlier in the Table of Contents controls. In the event that the Parties need to look outside of this Contract for interpreting its terms, the Parties shall consider only the following sources, as in effect at the time of interpretation, in the order of precedence listed:

1. The Oregon State Medicaid Plan and any Grant Award Letters, waivers or other directives or permissions approved by CMS for operation of the Oregon Health Plan (OHP).

2. The Federal Medicaid Act, Title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP), established by Title XXI of the Social Security Act, and the Patient Protection and Affordable Care Act (PPACA), and their implementing regulations published in the Code of Federal Regulations (CFR), except as waived by CMS for the OHP.

3. The Oregon Revised Statutes (ORS) concerning the OHP.

4. The Oregon Administrative Rules (OAR) promulgated by OHA or by the Department of Human Services (DHS) prior to the effective date of this Contract, to implement the OHP. In the event any DHS rule referenced in this Contract is readopted by OHA, this Contract shall be deemed to refer to the successor OHA rule.

5. Other applicable Oregon statutes and OARs concerning the Medical Assistance Program and health services.

C. If Contractor believes that any provision of this Contract or OHA's interpretation thereof is in conflict with federal or State statutes or regulations, Contractor shall notify OHA in writing immediately.

If any provision of this Contract is in conflict with applicable federal Medicaid or CHIP statutes or regulations that CMS has not waived for the OHP, the Parties shall amend this Contract to conform to the provision of those laws or regulations.

VII. Contractor Data and Certification

A. Contractor Information. This information is requested pursuant to ORS 305.385.

Please print or type the following information

If Contractor is self-insured for any of the Insurance Requirements specified in Exhibit F of this Contract, Contractor may so indicate by: (i) writing "Self-Insured" on the appropriate line(s); and (ii) submitting a certificate of insurance as required in Exhibit F, Section 9.

NAME (exactly as registered with the Oregon Corporation Division, not an assumed business name):

_____

Address: _____

Telephone: ( ) _____ Facsimile Number: ( ) _____

E-mail address: _____

Proof of Insurance:

Workers Compensation – Insurance Company _____

Policy # _____ Expiration Date: _____

Professional Liability Insurance Company _____

Policy # _____ Expiration Date: _____

General Liability Insurance Company _____

Policy # _____ Expiration Date: _____

Auto Insurance Company _____

Policy # _____ Expiration Date: _____

The above information must be provided prior to Contract execution. Contractor shall provide proof of Insurance upon request by OHA.

B. Certification. By signature on this Contract, the undersigned hereby certifies under penalty of perjury that:

1. The undersigned is authorized to act on behalf of Contractor and that Contractor is, to the best of the undersigned's knowledge, not in violation of any Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means a State tax imposed by ORS 320.005 to 320.150 and 403.200 to 403.250 and ORS 118, 314, 316, 317, 318, 321 and 323 and the elderly rental assistance program under ORS 310.630 to 310.706; and local taxes administered by the Department of Revenue under ORS 305.620;

2. The information shown in Part VII, Section A, "Contractor Data and Certification" above is Contractor's true, accurate and correct information;

3. Contractor and Contractor's employees and agents are not included on the list titled "Specially Designated Nationals and Blocked Persons" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: http://www.treas.gov/offices/enforcement/ofac/sdn/t11sdn.pdf;

4. Contractor is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Nonprocurement Programs" found at: http://www.epls.gov/;

5. Contractor is not subject to backup withholding because:

a. Contractor is exempt from backup withholding;

b. Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of a failure to report all interest or dividends; or

c. The IRS has notified Contractor that Contractor is no longer subject to backup withholding.

6. Contractor's Federal Employer Identification Number (FEIN) provided on the CP 385 form is true and accurate. If this information changes, Contractor shall provide OHA with the new FEIN within 10 days.

VIII. Signatures

CONTRACTOR

By _____ _____
Authorized Date

Title _____

OHA – ADDICTIONS AND MENTAL HEALTH DIVISION

By _____ _____
OHA Date

OHA - DIVISION OF MEDICAL ASSISTANCE PROGRAMS

By _____ _____
OHA Date

Approved as to Legal Sufficiency:

Approved by Theodore C. Falk, Senior Assistant Attorney General, July 23, 2012, email in Contract file.

Reviewed by Office of Contracts & Procurement:

By _____ _____
Tammy L. Hurst, Contract Specialist Date

Exhibit A - Definitions

In addition to any terms that may be defined elsewhere in this Contract and with the following exceptions and additions, the terms in this Contract have the same meaning as those terms appearing in OARs 309-012-0140, 309-016-0605, 309-032-0180, 309-032-0860, 309-032-1505, 309-033-0210, 410-120-0000, 410-141-0000 and 410-141-3000. The order of preference for interpreting conflicting definitions in this Contract is (in descending order of priority) CCO Administrative Rules of OHA, General Rules of OHA, Addictions and Mental Health Rules of OHA, and the definitions below. The following terms shall have the following meanings when capitalized:

For purposes of this Contract, the terms below shall have the following meanings when capitalized:

1. Terms Defined in OAR 410-141-0000

Coordinated Care Services
CCO Payment
Cold Call Marketing
Community Advisory Council (CAC)
Coordinated Care Organization (CCO)
Corrective Action or Corrective Action Plan
Covered Services
Declaration for Mental Health Treatment
Dental Care Organization (DCO)
Diagnostic Services
Exceptional Needs Care Coordination (ENCC)
Fully Capitated Health Plan (FCHP)
Health Services
Health System Transformation (HST)
Marketing
Mental Health Assessment
Mental Health Organization (MHO)
Non-Participating Provider
Participating Provider
Physician Care Organization (PCO)
Prioritized List of Health Services
Service Area
Service Authorization Request

2. Terms defined in OAR 410-120-0000

Abuse
Acute
Addictions and Mental Health Division (AMH)
Advance Directive
Aging and People with Disabilities (APD)
Adverse Event
Allied Agency
Ambulance
American Indian/Alaska Native (AI/AN)
American Indian/Alaska Native (AI/AN) Clinic
Ancillary Services
Area Agency on Aging (AAA)
Automated Voice Response (AVR)
Benefit Package
Children's Health Insurance Program (CHIP)
Citizen/Alien-Waived Emergency Medical (CAWEM)
Claimant
Client
Clinical Record
Contested Case Hearing
Co-Payments
Cost Effective
Date of Service
Dental Services
Dentist
Diagnosis Related Group (DRG)
Member
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)
Electronic Data Interchange (EDI)
EDI Submitter
Emergency Department
Emergency Medical Transportation
Evidence-Based Medicine
False Claim
Family Planning Services
Federally Qualified Health Center (FQHC)
Fee-for-Service Provider
Flexible Service
Flexible Service Approach
Fraud

Fully Dual Eligible
Healthcare Common Procedure Coding System (HCPCS)
Health Evidence Review Commission
Home Health Agency
Home Health Services
Hospice
Hospital
Hospital-Based Professional Services
Hospital Laboratory
Indian Health Care Provider
Indian Health Service (IHS)
Individual Adjustment Request Form (DMAP 1036)
Inpatient Hospital Services
Institutional Level of Income Standards (ILIS)
Institutionalized
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
Laboratory
Licensed Direct Entry Midwife
Liability Insurance
Managed Care Organization (MCO)
Maternity Case Management
Medicaid
Medical Assistance Eligibility Confirmation
Medical Assistance Program
Medical Care Identification
Medical Services
Medical Transportation
Medically Appropriate
Medicare Advantage
Medicare
Medicare Prescription Drug Coverage (Part D)
Medicheck for Children and Teens
Mental Health Case Management
National Correct Coding Initiative (NCCI)
National Provider Identification (NPI)
Non-covered Services
Nurse Practitioner
Nursing Facility
Nursing Services
Occupational Therapy
Ombudsman Services
Oregon Health Authority (OHA)
Oregon Health Plan (OHP) Client (Client)
Oregon Youth Authority (OYA)
Out-of-State Providers
Outpatient Hospital Services
Overdue Claim
Overpayment
Overuse
Panel
Payment Authorization
Peer Review Organization (PRO)
Pharmaceutical Services
Pharmacist
Physician
Physician Assistant
Post-Payment Review
Practitioner
Prepaid Health Plan (PHP)
Primary Care Physician
Primary Care Provider (PCP)
Prior Authorization (PA)
Prioritized List of Health Services
Private Duty Nursing Services
Provider
Provider Organization
Public Health Clinic
Public Rates
Qualified Medicare Beneficiary (QMB)
Quality Improvement
Quality Improvement Organization (QIO)
Recipient
Recoupment
Referral
Remittance Advice (RA)
Request for Hearing
Retroactive Medical Eligibility
Rural
Sanction
School Based Health Service
Service Agreement
Sliding Fee Schedule
Speech-Language Pathology Services
Spend-Down
State Facility
Subparts (of a Provider Organization)
Subrogation
Surgical Assistant
Suspension
Termination
Third Party Resource (TPR)
Transportation
Type A Hospital
Type B AAA
Type B AAA Unit
Type B Hospital
Urgent Care Services
Usual Charge (UC)
Utilization Review (UR)

3. Terms Defined by Statute

In this Contract, the following terms have the meanings defined in ORS 414.025:

(1) Alternative payment methodology
(2) Category of aid
(3) Categorically needy
(4) Community health worker
(9) Income
(13) Patient centered primary care home
(14) Peer wellness specialist
(15) Person centered care
(16) Personal health navigator
(17) Quality measure
(18) Resources

4. Terms Defined by this Contract

a. **"Action"** means:

(1) The denial or limited authorization of a requested Covered Service, including the type or level of service;

(2) The reduction, suspension or termination of a previously authorized service;

(3) The denial in whole or in part, of payment for a service;

(4) Failure to provide services in a timely manner, as defined by OHA;

(5) The failure of Contractor to act within the timeframes provided in 42 CFR 438.408(b); or

(6) For a Member who resides in a Rural Service Area where Contractor is the only CCO, the denial of a request to obtain Covered Services outside of Contractor's Participating Provider network under any of the following circumstances:

(i) The service or type of Provider (in terms of training, experience and specialization) is not available within the network;

(ii) The Provider is not part of the network, but is the main source of a service to the Member – provided that (a) the Provider is given the same opportunity to become a Participating Provider as other similar Providers; and (b) if the Provider does not choose to become a Participating Provider, or does not meet the qualifications, the Member is given a choice of Participating Providers and is transitioned to a Participating Provider within 60 days;

(iii) The only Provider available does not provide the service because of moral or religious objections;

(iv) The Member's Provider determines that the Member needs related services that would subject the Member to unnecessary risk if received separately and not all other related services are available with the network; or

(v) OHA determines that other circumstances warrant out-of-network treatment.

b. **"Acute Inpatient Hospital Psychiatric Care"** means Acute care provided in a psychiatric hospital with 24-hour medical supervision.

c. **"Appeal"** means a request for review of an Action.

d. **"Assessment"** means the determination of a person's need for Covered Services. It involves the collection and evaluation of data pertinent to the person's history and current problem(s) obtained through interview, observation, and record review.

e. **"Business Day"** means any day except Saturday, Sunday or a legal holiday. The word "day" not qualified as Business Day means calendar day.

f. **"Certified or Qualified Health Care Interpreter"** means a trained person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into spoken English, and who is readily able to translate the written or oral statements of other persons into the spoken language of the person with limited English proficiency. A certified Health Care Interpreter is trained and has received certification from a national certification body; a qualified Health Care Interpreter is trained and has demonstrated language proficiency in English and a second language where certification is not possible using a standardized, nationally recognized language proficiency assessment.

g. **"Civil Commitment"** means the legal process of involuntarily placing a person, determined by the Circuit Court to be a mentally ill person as defined in ORS 426.005 (1) (d), in the custody of OHA. OHA has the sole authority to assign and place a committed person to a treatment facility. OHA has delegated this responsibility to the CMHP Director.

h. **"Clinical Reviewer"** means the entity individually chosen to resolve disagreements related to a Member's need for LTPC immediately following an Acute Inpatient Hospital Psychiatric Care stay.

i. **"Cold Call Marketing"** means any unsolicited personal contact by Contractor with a Potential Member for Marketing as defined in this Contract.

j. **"Community"** means the groups within the geographic area served by a CCO and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the Service Area.

k. **"Cultural Competence"** Cultural Competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. OAR 415-056-0005. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.

l. **"Early Intervention"** means the Provision of Covered Services directed at preventing or ameliorating a mental disorder or potential disorder during the earliest stages of onset or prior to onset for individuals at high risk of a mental disorder.

m. **"Effective Date"** means the date this Contract becomes effective, as described in Section I.A.

n. **"Electronic Health Record"** means an electronic record of an individual's health-related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care provider.

o. **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

p. **"Emergency Psychiatric Hold"** means the physical retention of a person taken into custody by a peace officer, health care facility, State Hospital, hospital or nonhospital facility as ordered by a Physician or a CMHP director, pursuant to ORS Chapter 426.

q. **"Emergency Services"** means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

r. **"Evaluation"** means a psychiatric or psychological Assessment used to determine the need for mental health or substance use disorder services. The Evaluation includes the collection and analysis of pertinent biopsychosocial information through interview, observation, and psychological and neuropsychological testing. The Evaluation concludes with a five axes Diagnosis of a DSM multiaxial Diagnosis, prognosis for rehabilitation, and treatment recommendations.

s. **"Family"** means parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship.

t. **"Geropsychiatric Treatment Service" or "GTS"** means four units at the State hospital serving frail elderly persons with mental disorders, head trauma, advanced dementia, and/or concurrent medical conditions who cannot be served in community programs.

u. **"Grievance"** means a Member's or Member Representative's expression of dissatisfaction to Contractor or to a Participating Provider about any matter other than an Action.

v. **"Innovator Agent"** means an OHA employee who, upon request, is assigned to a CCO and serves as the single point of contact between a CCO and the OHA to facilitate the exchange of information between the CCO and the OHA.

w. **"Intensive Psychiatric Rehabilitation"** means the application of concentrated and exhaustive treatment for the purpose of restoring a person to a former state of mental functioning.

x. "**Invoiced Rebate Dispute**" means a disagreement between a pharmaceutical **manufacturer** and the Contractor regarding the dispensing of pharmaceuticals, as submitted by OHA to Contractor through the Pharmacy Drug Rebate Dispute Resolution Process in Exhibit B, Part 8, Section 10.

y. **"Learning Collaborative"** means a program in which CCOs, state agencies, and patient-centered primary care homes can:

(1) Share information about Quality Improvement;

(2) Share best practices and emerging practices that increase access to culturally competent and linguistically appropriate care and reduce health disparities;

(3) Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care;

(4) Coordinate efforts to develop and test methods to align financial incentives to support patient centered primary care homes;

(5) Share best practices for maximizing the utilization of patient centered primary care homes by individuals enrolled in medical assistance programs, including culturally specific and targeted outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;

(6) Coordinate efforts to conduct research on patient centered primary care homes and evaluate strategies to implement the patient centered primary care home to improve health status and quality and reduce overall health care costs; and

(7) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services.

z. **"Licensed Mental Health Practitioner" or "LMP"** means a person who is a Physician, Nurse Practitioner or Physician's Assistant licensed to practice in the State of Oregon whose training, experience and competence demonstrates the ability to conduct a comprehensive Mental Health Assessment and provide Medication Management. The Local Mental Health Authority, pursuant to ORS 430.630 (LMHA) or Contractor must document that the person meets these minimum qualifications.

aa. **"Local Mental Health Authority" or "LMHA"** means local mental health authority" means one of the following entities:

(1) The board of county commissioners of one or more counties that establishes or operates a CMHP;

(2) The tribal council, in the case of a federally recognized tribe of AI/AN that elects to enter into an agreement to provide mental health services; or

(3) A regional local mental health authority comprising two or more boards of county commissioners.

bb. **"Long-Term Psychiatric Care" or "LTPC"** means inpatient psychiatric services delivered in an Oregon State-operated Hospital after Usual and Customary care has been provided in an Acute Inpatient Hospital Psychiatric Care Setting or The Joint Commission (TJC) Psychiatric Residential Treatment Facility for children under age 18 and the individual continues to require a hospital level of care.

cc. **"MHO Covered Service"** means those mental health services that are included in the CCO Payment paid to Contractor under this Contract with respect to an MHO Member whenever those mental health services are Medically Appropriate for the MHO Member. Services included in the CCO Payment are described in the State of Oregon, Oregon Health Plan Service Categories for Per Capita Costs. The CCO Payment for MHO Covered Services is based on the number of mental health Condition/Treatment Pair Lines of the List of Prioritized Health Services funded by the Legislature and adopted in OAR 410-141-0520. MHO Covered Services are limited in accordance with OAR 410-141-0500.

dd. **"MHO Emergency Services"** means health services from a qualified provider necessary to evaluate or stabilize an emergency mental health condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

ee. **"MHO Member"** for purposes of describing individuals receiving MHO Covered Services pursuant to Exhibit M means either:

(1) Is enrolled with an MHO but not with an FCHP or PCO, on the day before the date when the OHP Client's MHO becomes part of a CCO; or

(2) Receives health services on a fee-for-service basis but who is eligible for and is enrolled in a CCO for MHO Covered Services on or after November 1, 2012.

For all other purposes in this Contract, apart from the requirements for provision of covered services that are limited to MHO Covered Services, an MHO Member is a Member of the CCO.

ff. **"Marketing"** means any communication, from Contractor to an OHP Client who is not enrolled with Contractor, that can reasonably be interpreted as intended to influence the OHP Client to enroll with Contractor, or either to not enroll in, or to disenroll from, another PHP.

gg. **"Marketing Materials"** means any medium produced by, or on behalf of, Contractor that can reasonably be interpreted as intended for Marketing.

hh. **"Material Change"** means any circumstance in which Contractor experiences a change in operations that is reasonably likely to affect Contractor's Participating Provider capacity or reduce or expand the amount, scope or duration of Covered Services being provided to Members including but not limited to:

(1) Changes in Contractor's service delivery system that may directly impact the provision of services to Members or affect Provider participation;

(2) Expansion or reduction of a Service Area requiring a Contract amendment, particularly related to Provider capacity and service delivery in the affected Service Area;

(3) Modifications of Provider payment processes or mechanisms that could affect Provider participation levels;

(4) Enrollment of a new population (e.g., roll over or new OHP Benefit Package recipients);

(5) Loss of or addition of a Participating Provider, specialty Provider, clinic or hospital, previously identified on the Provider Capacity Report that will impact Members.

ii. **"Member"** means a Client who is enrolled with Contractor under this Contract.

jj. **"Mental Health Practitioner"** means a person with current and appropriate licensure, certification, or accreditation in a mental health profession, which includes but is not limited to: psychiatrists, psychologists, registered psychiatric nurses, QMHAs, and QMHPs.

kk. **"Metrics and Scoring Committee"** means the committee established in accordance with ORS 414.638(1).

ll. **"Oregon Integrated and Coordinated Health Care Delivery System"** means the system for OHP and **individuals** who are dually eligible for Medicare and Medicaid that makes CCOs accountable for care management and provision of integrated and coordinated health care for each Members, managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.

mm. **"Oregon Patient/Resident Care System" or "OP/RCS"** means the OHA data system for persons receiving services in the Oregon State Hospitals and selected community hospitals providing Acute Inpatient Hospital Psychiatric services under contract with OHA.

nn. **"Outreach"** means services provided away from the service provider's office, clinic or other place of business in an effort to identify, engage or serve Members who might not otherwise access, obtain, keep or benefit from usual appointments. Such services include, but are not limited to, community-based visits with a Member in an attempt to engage him or her in Medically Appropriate treatment, and providing Medically Appropriate treatment in a setting more natural or comfortable for the Member.

oo. **"Patient Protection and Affordable Care Act" or "PPACA"** means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as modified by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

pp. **"Payment"** means a CCO Payment as defined in this Exhibit A or a supplemental payment described in Exhibit C.

a. **"Post Stabilization Services"** means Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

qq. **"Potential Member"** means an OHP Client who is subject to mandatory Enrollment or may voluntarily elect to enroll in a CCO, but is not yet enrolled with a specific CCO.

rr. **"Provider Panel" or "Provider Network"** means those Participating Providers affiliated with the Contractor who are authorized to provide services to Members.

ss. **"Psychiatric Security Review Board" or "PSRB"** means the Board authorized under ORS Chapter 161 which has jurisdiction over persons who are charged with a Tier One crime and found guilty except for insanity.

tt. **"Qualified Mental Health Associate" or "QMHA"** means a person delivering services under the direct supervision of a QMHP and meeting the following minimum qualifications as documented by Contractor: a bachelor's degree in a behavioral sciences field; or a combination of at least three years' relevant work, education, training or experience; and has the competencies necessary to communicate effectively; understand mental health Assessment, treatment and service terminology and to apply the concepts; and Provide psychosocial Skills Development and to implement interventions prescribed on a treatment plan within their scope of practice.

uu. **"Qualified Mental Health Professional" or "QMHP"** means a LMP or any other person meeting the following minimum qualifications as documented by Contractor: graduate degree in psychology; bachelor's degree in nursing and licensed by the State of Oregon; graduate degree in social work; graduate degree in behavioral science field; graduate degree in recreational, art, or music therapy; or bachelor's degree in occupational therapy and licensed by the State of Oregon; and whose education and experience demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess Family, social and work relationships; conduct a mental status examination; document a multiaxial DSM Diagnosis; write and supervise a treatment plan; conduct a Comprehensive Mental Health Assessment; and Provide Individual Therapy, Family Therapy, and/or Group Therapy within the scope of their training.

vv. **"Region"** means the geographical boundaries of the area served by a CCO as well as the governing body of each county that has jurisdiction over all or part of the Service Area.

ww. **"Request for Applications" or "RFA"** means OHA Request for Applications # 3402 for Coordinated Care Organizations (CCOs).

xx. **"SB 1580 (2012)"** means 2012 Oregon Laws, Chapter 8, Enrolled SB 1580 (2012).

yy. **"Services Coordination"** means Services provided to Members who require access to and receive Covered Services, or long term care services, or from one or more Allied Agencies or program components according to the treatment plan. Services provided may include establishing pre-commitment service linkages; advocating for treatment needs; and providing assistance in obtaining entitlements based on mental or emotional disability.

zz. **"Special Health Care Needs"** means individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorder either 1) have functional disabilities, or 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

aaa. **"State"** means the State of Oregon.

bbb. **"State Hospital Review Panel" or "SHRP"** means the panel authorized under ORS Chapter 161 to make decisions about the individuals who are charged with a Tier Two offense and found guilty except for insanity.

ccc. **"Subcontractor"** means any Participating Provider or any other individual, entity, facility, or organization that has entered into a subcontract with the Contractor or any Subcontractor for any portion of the Work under this Contract.

ddd. **"Substance Use Disorder Provider"** means a practitioner approved by OHA to provide publicly funded substance use disorder services.

eee. **"Therapeutic Abortion"** for purposes of this Contract means any abortion that does not arise under one of the following situations: the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a Physician, place the woman in danger of death unless an abortion is performed.

fff. **"Transitional care"** means assistance for a Member when entering and leaving an Acute care facility or a long term care setting.

ggg. **"Valid Claim"** means a Claim received by the Contractor for payment of Covered and non-Covered Services rendered to a Member which: (1) Can be processed without obtaining additional information from the Provider of the service; and (2) Has been received within the time limitations prescribed in OHP Rules. A "Valid Claim" does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A "Valid Claim" is a "clean claim" as defined in 42 CFR 447.45 (b).

1. Governing Board and Governance Structure

Contractor shall establish, maintain and operate with a governance structure that complies with the requirements of ORS 414.625(1)(o).

2. Community Advisory Council (CAC)

Contractor shall establish a CAC that includes appropriate community representation in each Service Area. The duties of the CAC shall include, the following, in collaboration with community partners:

a. Identifying and advocating for preventive care practices to be utilized by the Contractor;

b. Overseeing a Community Health Assessment and adopting a Community Health Improvement Plan to serve as a strategic plan for addressing health disparities and meeting health needs for the communities in the Service Area(s); and

c. Annually publishing a report on the progress of the community health improvement plan**.**

3. Clinical Advisory Panel

Contractor shall establish an approach within its governance structure to assure best clinical practices. This approach is subject to OHA approval, and may include a Clinical Advisory Panel (CAP). If Contractor convenes a CAP, it will include representation from behavioral health and physical health systems, and from oral health if and when oral health becomes part of the CCO.

4. Community Health Assessment and Community Health Improvement Plan

Contractor's CAC shall collaborate with the local public health authority, local mental health authority, community based organizations and hospital systems to develop a shared community health assessment and adopt a community health improvement plan with the responsibilities identified in Section 2 above and in OAR 410-141-3145. Community health assessment shall include identification and prioritization of health disparities among the CCO's diverse communities, including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, occupation, and other factors in its Service Areas. The community health assessment and community health improvement plan shall be conducted so that they are transparent and public in both process and outcomes.

a. The community health assessment and community health improvement plan adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The activities, services and responsibilities defined in the plan may include:

(1) Findings from the various community health assessments made available by the OHA to Contractor;

(2) Additional findings on health needs and health disparities from community partners or previous assessments;

(3) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(4) Description of how the community health assessment and community health improvement plan support the development, implementation, and evaluation of patient-centered primary care approaches;

(5) Description of how Health Systems Transformation objectives are addressed in the community health assessment and community health improvement plan;

(6) System design issues and solutions;

(7) Outcome and Quality Improvement plans and results;

(8) Integration of service delivery approaches and outcomes; and

(9) Workforce development approaches and outcomes.

Contractor and Contractor's CAC shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

b. Contractor, through its CAC, shall develop and implement a Community Health Improvement Plan, consistent with OAR 410-141-3145. The Community Health Improvement Plan shall identify the findings of the Community Health Assessment and the method for prioritizing health disparities for remedy. Contractor will provide a copy of the Community Health Improvement Plan, and annual updates to the Community Health Improvement Plan, to OHA.

1. Covered Services

Contractor shall provide and pay for Coordinated Care Services that are covered health services listed in this Exhibit B, in exchange for a CCO Payment based on its Global Budget.

Coordinated Care Services include the provision of Flexible Services and Supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or Support must be ordered by and under the supervision of a PCPCH or other primacy care provider in the Contractor's Delivery System Network when authorized in accordance with CCO policy for authorizing Flexible Services or Supports.

In addition to traditional Medicaid service and supports for physical health, mental health and addictions treatment, and Dental Services, Covered Services may include the provision of Flexible Services and Supports that are consistent with achieving Member wellness and the objectives of an individualized care plan. Contractor shall establish a policy in conjunction with OHA for authorizing Flexible Services and Supports that enables a Network Provider to order and supervise the provision of a Flexible Service

a. Services not reimbursed under this Contract: Health services that are not Covered Services are authorized and paid outside of this Contract according to procedures provided in the General Rules and OHA Provider rules, or by separate contract, and are not included in the Global Budget. This includes services for:

(1) Physician assisted suicide under the Oregon Death with Dignity Act, ORS 127.800-127.897;

(2) Therapeutic abortions;

(3) Non-emergency medical transportation, which is transportation other than those classified as Ambulance service(s);

(4) Residential substance use disorder services; however, CCO must have contracts for residential substance use disorder services in effect not later than July 1, 2013;

(5) Dental Services that are Covered Services under the DCO contract; however, on or before July 1, 2014, Contractor must have a formal contractual relationship with any DCO that serves Members in the area where they reside;

(6) Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy. These medications are paid through OHA's Fee for Service system;

(7) Hospice services for Members who reside in a skilled Nursing Facility;

(8) Long-term psychiatric care at the Oregon State Hospital, Secure Children's Inpatient Program and Secure Adolescent Inpatient Program; and

(9) Long Term Care Services excluded from Contractor reimbursement pursuant to ORS 414.631.

b. Contractor should inform OHA in advance of the effective date of its contracts for residential substance use disorder services or Dental Services under a DCO contract, to allow sufficient time to amend the contract if needed.

2. OHP Plus and OHP Standard Benefit Packages of Covered Services

a. Subject to the provisions of this Contract, Contractor shall provide for Covered Services to Members eligible for the OHP Plus Benefit Package and the OHP Standard Benefit Package.

(1) Contractor shall provide the OHP Plus Benefit Package of Covered Services, OAR 410-141-2480 and OAR 410-120-1210 including Diagnostic Services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.

(2) Contractor shall provide treatment, including Ancillary Services, which is included in or supports the Condition/Treatment Pairs that are above the funding line on the Prioritized List of Health Services, OAR 410-141-2520.

(3) Except as otherwise provided in OAR 410-141-2480(7), Contractor is not responsible for excluded or limited services as defined in OAR 410-141-2500.

(4) Before denying treatment for a condition that is below the funding line on the Prioritized List for any Member, especially a Member with a disability or Co-morbid Condition, Contractor shall determine whether the Member has a funded condition and paired treatment that would entitle the Member to treatment under OAR 410-141-2480.

(5) Contractor shall notify OHA's Transplant Coordinator of all transplant prior authorizations. Contractor must use the same limits and criteria for transplants as those established in the Transplant Services Rules, OAR 410-124-0000 et seq.

b. Subject to the provisions of this Contract, Contractor is responsible for Coordinated Care Services for Full Dually Eligibles for Medicare and Medicaid. Contractor shall pay for Covered Services for Members who are Full Dually Eligible in accordance with applicable contractual requirements that include CMS and OHA.

3. Provision of Covered Service

a. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services.

b. Contractor shall provide to Members, at a minimum, those Covered Services that are Medically Appropriate and as described as funded condition-treatment pairs on the Prioritized List of Health Services contained in OAR 410-141-2520 and as identified, defined and specified in the OHP Administrative Rules.

c. Contractor shall ensure all Medically Appropriate Covered Services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to Clients under fee-for-service and as set forth in 42 CFR 438.210. Contractor also shall ensure that the Covered Services are sufficient in amount, duration and scope to reasonably

be expected to achieve the purpose for which the services are furnished and include the following:

(1) The prevention, diagnosis, and treatment of health impairments;

(2) The ability to achieve age-appropriate growth and development;

(3) The ability to attain, maintain or regain functional capacity.

d. Contractor shall establish written utilization management policies, procedures and criteria for Covered Services. These utilization management procedures must be consistent with appropriate utilization control requirements of 42 CFR Part 456.

e. Contractor's utilization management policies may not be structured so as to provide incentives for its Provider Network to inappropriately deny, limit or discontinue Medically Appropriate services to any Member.

4. Authorization or Denial of Covered Services

a. Contractor shall establish written procedures that Contractor follows, and requires Participating Providers to follow, for the initial and continuing authorizations of services as defined in OAR 410-141-0000. That procedure must require that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's health or mental health condition or disease in accordance with 42 CFR 438.210.

b. Contractor may require Members and Subcontractors to obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required in OAR 410-141-2420 or elsewhere in this Statement of Work.

c. Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to mental health or alcohol and drug Assessment and Evaluation services. Members may refer themselves to mental health and substance use disorder services.

d. Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.

e. For standard service authorization requests, Contractor shall provide notice as expeditiously as the Member's health or mental health condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of 14 additional calendar days if the Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest. If Contractor extends the time frame, Contractor shall provide the Member and Provider with a written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a service authorization request within the timeframes specified above, Contractor shall issue a Notice of Action (NOA) to the Provider and Member, or Representative, consistent with Exhibit I, Grievance System.

f. If a Member or Provider requests, or Contractor determines, that following the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide Notice as expeditiously as the Member's mental health condition requires and no later than three working days after receipt of the request for service. Contractor may extend the three working day time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

g. Contractor may not restrict coverage for any hospital length of stay following a normal vaginal birth to less than 48 hours, or less than 96 hours for a cesarean section. An exception to the minimum length of stay may be made by the Physician in consultation with the mother, which must be documented in the Clinical Record.

h. Contractor shall ensure the provision of sexual abuse exams without prior authorization.

i. Contractor shall coordinate preauthorization and related services with DCOs to ensure the provision of dental care with mutual Members that must be performed in an outpatient hospital or ASC due to the age, disability, or medical condition of the Member.

j. Except as provided in Subsection k. of this section, Contractor may not prohibit or otherwise limit or restrict Health Care Professionals who are its employees or Subcontractors acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the professional, for the following:

(1) For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under this Contract or is subject to Co-Payment;

(2) Any information the Member needs in order to decide among relevant treatment options;

(3) The risks, benefits, and consequences of treatment or non-treatment; and

(4) The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

k. Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service, because of the requirement in Subsection j. of this section, if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds under this paragraph, Contractor shall adopt a written policy consistent with the provisions of 42 CFR 438.10 for such election and furnish information about the services Contractor does not cover as follows:

(1) To OHA:

(a) With Contractor's application for CCO certification; and

(b) Whenever Contractor adopts the policy during the term of this Contract, at least 30 days prior to Contractor's formal adoption of the policy; and

(2) Following certification, subject to OHA prior approval, to:

(a) Potential Members before and during Enrollment; and

(b) Members within 90 days after adopting the policy with respect to any particular service.

l. Contractor shall notify the requesting Provider, in writing or orally, when Contractor denies a request to authorize a Covered Service or when the authorization is in an amount, duration, or scope that is less than requested.

m. Contractor shall notify the Member in writing of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested pursuant to the requirements of Exhibit I.

5. Services Coordination for Non-covered Health Services

a. Contractor shall coordinate services for each Member who requires health services not covered under the CCO Payment. For the purpose of achieving appropriate health outcomes, Contractor shall coordinate health services that are not covered within the Member's Benefit Package.

b. Contractor shall assist its Members in gaining access to certain substance use disorder and mental health services that are not Covered Services and that are provided under separate contract with OHA, including but are not limited to the following:

(1) Medical Transportation pursuant to rules (OAR 410-136-0020 et. seq.) promulgated by OHA and published in its Medical Transportation Services Guide;

(2) Standard therapeutic class 7 & 11 Prescription drugs, Depakote, Lamictal and their generic equivalents dispensed through a licensed pharmacy. These medications are paid through OHA's Fee for Service system;

(3) Therapeutic Foster Care reimbursed under HCPCs Code S5146 for Members under 21 years of age;

(4) Therapeutic group home reimbursed for Members under 21 years of age;

(5) Behavioral rehabilitative services that are financed through Medicaid and regulated by DHS Child Welfare and OYA;

(6) Investigation of Members for Civil Commitment;

(7) Long Term Psychiatric Care (LTPC) as defined for Members 18 years of age and older;

(8) Preadmission Screening and Resident Review (PASRR) for Members seeking admission to a LTPC;

(9) LTPC for Members age 17 and under;

(a) Secure Children's Inpatient program (SCIP)

(b) Secure Adolescent Inpatient Program (SAIP)

(c) Stabilization and transition services (STS)

(10) Personal care in adult foster homes for Members 18 years of age and older;

(11) Residential mental health services for Members 18 years of age and older provided in licensed community treatment programs;

(12) Residential substance use disorder services provided in OHA approved community treatment programs however, CCO must have contracts for residential substance use disorder services in effect not later than July 1, 2013;

(13) Abuse investigations and protective services as described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765; and

(14) Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.

6. Covered Service Components

Without limiting the generality of Contractor's obligation to provide integrated care and coordination for Covered Services, the following responsibilities are required by law, and must be implemented in conjunction with its integrated care and coordination responsibilities stated above.

a. Emergency and Urgent Care Services

(1) Contractor shall establish written policies and procedures and monitoring systems that provide for Emergency Services including post-stabilization care services, and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114.

The emergency response system must include the necessary array of services to respond to mental health crises, that may include crisis hotline, mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.

Contractor's policies and procedures shall include an emergency response system that provides an immediate, initial and/or limited duration response for potential mental health emergency situations or emergency situations that may include mental health conditions, which consist of: screening to determine the nature of the situation and the person's immediate need for Covered Services; capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of a written initial services plan at the conclusion of the Mental Health Assessment; provision of Covered Services and Outreach needed to address the urgent or emergency situation; and linkage with the public sector crisis services, such as pre-commitment.

(2) Contractor may not require prior authorization for Emergency Services. Contractor provides an after-hours call-in system adequate to Triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.

(3) Contractor shall cover and pay for Emergency Services as provided for in OAR 410-141-3140. Contractor shall cover and pay for post-stabilization services as provided for in OAR 410-141-3140 and 42 CFR 438.114.

b. Emergency Ambulance Transportation

(1) Contractor shall pay for emergency Ambulance transportation for Members including Ambulance services dispatched through 911, in accordance with the Emergency Services prudent layperson standard described in Exhibit A, definitions for "Emergency Services" and "Emergency Medical Condition".

(2) Unless Contractor has authorized non-emergency medical transportation, Contractor is not responsible for non-emergency medical transportation. Payment for non-emergency medical transportation that has not been prior authorized by Contractor is governed by the Medical Transportation Services rules, OAR 410-136-0030 through OAR 410-136-0860. Contractor should coordinate with the Member's transportation needs when arranging for provision of Coordinated Care Services.

c. Preventive Care

(1) Contractor shall provide Preventive Services, which are those services promoting health and/or reducing the risk of disease or illness included under OAR 410-120-1210, 410-141-0480 and 410-141-0520. Such services include, but are not limited to, periodic medical examinations based on age, gender and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors.

(2) Preventive services screening and counseling content is based on age and risk factors determined by a comprehensive patient history. Contractor must provide all necessary diagnosis and treatment services identified as a result of such screening to the extent such services are Coordinated Care Services. To the extent such services are not Coordinated Care Services, but are Medical Case Management Services, Contractor must refer the Member to an appropriate Participating or Non-Participating Provider and manage and coordinate the services.

(3) For Preventive Care Services provided through any Subcontractors (including, but not limited to, Federally Qualified Health Centers, Rural Health Clinics, and County Health Departments), Contractor shall require that all services provided to Members are reported to Contractor and are subject to Contractor's Medical Case Management and Record Keeping responsibilities.

(4) Contractors shall comply with the mission, objectives, and guidelines of the Quality and Performance Improvement Workgroup, as posted on OHA's web site. This includes, but is not limited to, specific prevention projects, both at the Contractor and State levels, collection and measurement of data, and regular intervals of data submissions.

d. Family Planning Services

Members may receive Covered Services for Family Planning from any OHA Provider as specified in the Social Security Act, Section 1905 [42 U.S.C. 1396d], 42 CFR 431.51 and defined in OAR 410-130-0585. To the extent the Member chooses to receive such services

without Contractor's authorization from a Provider other than Contractor or its Subcontractors, Contractor is not be responsible for payment, Case Management, or Record Keeping.

e. Sterilizations and Hysterectomies

(1) Sterilizations and Hysterectomies are a Covered Service only when they meet the federally mandated criteria 42 CFR 441.250 to 441.259 and the requirements of OHA established in OAR 410-130-0580. Representatives may not give consent for sterilizations.

(2) Contractor shall submit a signed informed consent form to OHA for each Member that received either a hysterectomy or sterilization service as described in Section 6.e.1. Contractor may submit copies of informed consent forms upon receipt or when notified by OHA that a qualifying encounter claim has been identified.

(3) OHA will notify Contractor no later than 30 days past the end of each calendar quarter of Contractor's Members who received a hysterectomy or sterilization service. Contractor in turn shall supply the informed consent within 30 days of notification to the Contractor's designated Encounter Data Liaison.

(4) OHA in collaboration with Contractor reconciles all hysterectomy or sterilization services with informed consents with the associated encounter Claims by either:

(a) Confirming the validity of the consent and notifying Contractor that no further action is needed,

(b) Requesting a corrected informed consent form, or

(c) Informing Contractor the informed consent is missing or invalid and the payment must be recouped and the associated encounter Claim must be changed to reflect no payment made for service(s).

(5) Contractor will be subject to overpayment recovery as described in Exhibit D, Section 7 of this Contract for failure to comply with the requirements of this section.

f. Post Hospital Extended Care (PHEC) Coordination

(1) PHEC is a 20-day benefit included within the Global Budget payment. Contractor shall make the benefit available for non-Medicare Members who meet Medicare criteria for a post-hospital skilled Nursing Facility placement.

(2) Contractor shall notify the Member's local DHS APD office as soon as the Member is admitted to PHEC. The Contractor and APD will begin appropriate discharge planning.

(3) Contractors shall notify the Member and the facility of the proposed discharge date from PHEC no later than two full Business Days prior to discharge.

(4) Contractor shall provide the PHEC benefit according to the criteria established by Medicare, as cited in the Medicare Coverage of Skilled Nursing Facility Care available by calling 1-800-MEDICARE or at www.medicare.gov/publications.

(5) Contractor is not responsible for the PHEC benefit unless the Member was enrolled with Contractor at the time of the hospitalization preceding the skilled Nursing Facility placement.

g. Mental Health Conditions that may Result in Involuntary Psychiatric Care

(1) Contractor shall makes a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment in lieu of involuntary treatment.

(2) Contractor shall adopt written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold.

(3) Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340.

(4) Contractor shall comply with ORS Chapter 426, OAR 309-033-0200 through 309-033-0340 and 309-033-0400 through 309-033-0440 for involuntary Civil Commitment of those Members who are civilly committed under ORS 426.130.

(5) If Contractor believes a Member, over age 18 with no significant nursing care needs due to an Axis III disorder, is appropriate for Long Term Psychiatric Care (state hospital level of care), the Contractor shall request a LTPC determination from the OHA LTPC reviewer.

(6) Contractor shall assure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

h. Coordinated Care Services for Members and Long Term Psychiatric Care (LTPC)

(1) Age 17 and Under:

(a) If Contractor believes a Member is appropriate for LTPC, Contractor shall request a LTPC determination from the applicable OHA mental health program. The Medicaid Policy Unit staff will render a determination within seven working days of receiving a completed request, if the Member is age 17 and under, as described in Procedure for LTPC Determinations for Members age 17 and Under, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx;

(b) The AMH Child and Adolescent Mental Health Specialist will respond to Contractor no more than seven working days following the date OHA receives a completed request for LTPC determination form.

(c) Contractor shall work with the AMH Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC (SCIP and SAIP programs).

(d) The Member will remain enrolled with the Contractor for delivery of SCIP and SAIP services. Contractor shall bear care coordination responsibility for the entire length of stay, including admission determination and planning, linking the child and family team and Integrated Community Treatment Service (ICTS) Provider, services provided by LTPC service provider and transition and discharge planning. Contractor shall ensure that utilization of LTPC is reserved for the most Acute and complex cases and only for a period of time to remediate symptoms that led to admission.

(2) Age 18 and over

(a) If Contractor believes a Member:

(i) Age 18 to age 64 with no significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the LTPC reviewer as described in *Procedure for LTPC Determinations for Members Age 18-64*, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx. Adult Mental Health Services Unit staff will render a determination within three working days of receiving a complete request.

(ii) Age 65 and over, or age 18 to age 64 with significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the State hospital-GTS, Outreach and Consultation Service (OCS) Team as described in *Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment*, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx.

(b) A Member is appropriate for LTPC when the Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State hospital or extended care program, or extended and specialized medication adjustment in a secure or otherwise highly supervised environment; and the Member has received all usual and customary treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.

(c) OHA will cover the cost of LTPC of Members age 18 to 64 determined appropriate for such care beginning on the effective date specified below and ending on the date the Member is discharged from such setting.

If a Member is ultimately determined appropriate for LTPC, the effective date of such determination is either:

(i) Within three working days of the date AMH Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons Age 18 to 64 form; or

(ii) The date the State hospital -GTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State hospital-GTS; or

(iii) In cases where OHA and Contractor mutually agree on a date other than these dates, the date mutually agreed upon; or

(iv) In cases where the Clinical Reviewer determines a date other than a date described above, the date determined by the Clinical Reviewer.

In the event Contractor and AMH Adult Mental Health Services Unit staff disagree about whether a Member 18 to 64 is appropriate for LTPC, Contractor may request, within three working days of receiving notice of the LTPC determination, review by an independent Clinical Reviewer. The determination of the Clinical Reviewer will be deemed the determination of OHA for purposes of this Contract. If the Clinical Reviewer ultimately determines that the Member is appropriate for LTPC, the effective date of such determination will be the date specified above Paragraph (c). The cost of the clinical review will be divided equally between Contractor and OHA.

(d) For Members age 18 and older, Contractor shall work with the appropriate AMH Team in managing admissions to and discharges from LTPC for Members who require such care at a State hospital, to ensure that Members are served in and transition into the most appropriate, independent, and integrated community-based setting possible.

(e) For the Member age 18 and over, including those Members in the long term geropsychiatric care at the State hospitals, Contractor shall work with the Member to assure timely discharge from LTPC to the most appropriate, independent and integrated community-based setting possible.

(f) For the Member and the parent or guardian of the Member, the care coordinator and the child and family team will work to assure timely discharge from a psychiatric residential treatment facility to the most appropriate, independent and integrated community-based setting possible.

(g) Contractor shall authorize and reimburse Care Management services that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed community treatment programs.

(h) Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

i. Acute Inpatient Hospital Psychiatric Care

(1) Contractor shall provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC.

(2) Contractor shall submit required data through the Oregon Patient/Resident Care System (OPRCS).

(3) Contractor shall require employees or Subcontractors providing Mental Health Services to provide AMH, within 30 days of admission or discharge, with all information required by AMH's most current reporting system, currently "Client Process Monitoring System" (CPMS).

j. Adult Mental Health

(1) Contractor shall develop and implement an adult mental health system that provides cost-effective, comprehensive, person-centered, individualized, integrated community-based care to Members.

(2) Contractor shall provide oversight, care coordination and transition and planning management of Members within the targeted population of AMH to ensure culturally and linguistically appropriate community-based care is provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care.

(3) Contractor shall ensure access to referral and screening at multiple entry points.

(4) Contractor shall adopt policies and procedures to assess all Members who are suspected of having significant mental or emotional disorders.

(5) Contractor shall adapt the intensity, frequency and blend of these services to the mental health needs of the Member, based on a standardized assessment tool approved by OHA.

(6) Contractor shall report outcomes and data via the Adult Mental Health Initiative reporting tool.

k. Children's Mental Health

Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care for Members 17 and under, in the care and custody of DHS Child Welfare or OYA in coordination with the care coordinator. For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), Contractor shall also coordinate with such Member's parent or legal guardian.

(1) Integrated Service Array (ISA) for Children and Adolescents

(a) The ISA is a range of service components for children and adolescents, through and including age 17. These services target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings. Contractor shall ensure that the ISA will be recovery focused, family guided, and time limited based on Medically Appropriate criteria.

(b) Contractor shall establish a system that promotes collaboration, within laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families, and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges. Contractor must ensure health care assessments for children and adolescents are conducted within 60 days after being placed under Child Welfare custody.

(c) Contractor shall provide services that are family-driven, strengths-based, culturally and linguistically appropriate, and that enhance and promote quality, community-based service delivery.

(d) Contractor shall use the Child and Adolescent Service Intensity Instrument (CASII) as the statewide tool to assist in the determination for ISA services for children age 6 and older. For children 5 and younger, the statewide tool will be the Early Childhood Service Intensity Instrument (ECSII).

(e) Contractor shall prioritize children with the most serious mental health needs for the ISA who have a mental health diagnosis that is on or above the funded line of the OHP Prioritized List of Health Services. This mental health diagnosis must be the focus of the ISA and the treatment plan. In addition to considering the level of service intensity need indicated by the CASII or ECSII score, Contractor shall take into consideration factors including, but not limited to:

(i) Exceeding usual and customary services in an outpatient setting;

(ii) Multiple agency involvement;

(iii) History of one or more out-of-home placements;

(iv) Significant risk of out-of-home placement;

(v) Frequent or imminent admission to Acute inpatient psychiatric hospitalizations or other intensive treatment services;

(vi) Caregiver stress;

(vii) School disruption due to mental health symptomatology;

(viii) Elevating or significant risk of harm to self or others; and

(ix) For children birth to 5:

(A) History of abuse or neglect;

(B) Conditions interfering with parenting, such as poverty, substance abuse, mental health problems, and domestic violence, and

(C) Significant relationship disturbance between parent(s) and child.

(f) Contractor shall clearly communicate the ISA determination process to Family members, guardians, and community partners, and shall encourage ISA referrals from multiple sources, including families, Allied Agencies, schools, juvenile justice, the faith community and health care providers.

(g) Contractor shall make decisions regarding ISA determinations and referrals to services within three working days consistent with Contractor's policies and procedures.

(h) For Members meeting the determination process outlined in Paragraph (B) above, for intensive treatment services have access to care coordination, Contractor shall have available a child and family team planning process and access to the ISA.

(i) Contractor shall submit written policies and procedures for CASII and ECSII administration and ISA determination processes to AMH's Mental Health Medicaid Policy Unit by February 1st of each year. The policy unit will review the policies and procedures and notify Contractor of its determination of the review and approval within 30 days of receipt.

(j) Contractor shall ensure that Service Coordination will be provided by a person or persons who have a strong child and adolescent mental health background, extensive knowledge of the children's system of care, and experience working with families.

(k) Contractor shall have a child and family team assist in the development of the Service Coordination plan. The team may include the child, if appropriate, Family members, child serving agencies involved with the child, school, culturally specific community based organizations and other community supports identified by the Family.

(l) Contractor shall develop and implement a Community Care Coordination Committee that is a community level planning and decision making body to provide practice-level consultation, identify needed community services and supports, and provide a forum for problem solving to families, ISA providers, child serving agencies, and child and family teams. The Community Care Coordination Committee must have representation of the local system of care that includes Consumer and Family members, child serving providers, child and family advocates, culturally specific community based organizations, and other local stakeholders representative of the local system of care.

(m) Contractor shall serve any Member meeting criteria for the ISA, as described in this section, by a provider certified to provide intensive community based treatment services under OAR 309-032-1500 to 309-032-1565.

(n) Contractor shall adopt policies and procedures describing the admission and discharge criteria for a child or adolescent requiring the ISA level of care, with a process that includes the active participation of the Family, Allied Agencies, and other persons involved in the child's care.

(o) Contractor shall report on ISA system clinical outcomes by submitting a completed ISA Children's System Progress Review report, administered upon

entry, quarterly and upon exit, while Member receives ISA services. Data shall be reported no later than 30 days after entry into ISA services, every 90 days after the initial report and on exit from ISA services. Data shall be submitted electronically to the following web address: https://apps.state.or.us/cf1/amh/

l. Children's Wraparound Demonstration Project Responsibilities – limited to Contractors participating in the Demonstration Project

In service areas with currently funded Children's Wraparound Demonstration projects, Contractor shall create a system of care by implementing a Children's Wraparound Demonstration Project and by providing oversight and, in collaboration with OHA, evaluation.

Contractor shall develop local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

m. Substance Use Disorder

Contractor shall provide substance use disorder services to eligible Members, which include outpatient treatment services, Opiate Substitution Services, and Intensive outpatient treatment services. For purposes of this Contract, AMH rules and criteria applicable to outpatient treatment services are located in Integrated Services and Supports Rules (ISSR) OAR 309-032-0000, the AMH rules and criteria applicable to synthetic opiate treatment services located in OAR 415-020-0000 and the AMH rules and criteria applicable to detoxification centers located in OAR 415-0050-0000. For technical assistance related to this section of this Contract, the AMH contact will be the Medicaid Substance Use Disorder Specialist, AMH Medicaid Policy Unit.

(1) Contractor shall make decisions about access to substance use disorder services, continued stay, discharges, and referrals based upon AMH approved criteria, which are deemed to be Medically Appropriate. Contractor shall ensure that employees or Subcontractors who evaluate Members for access to and length of stay in substance use disorder services have the training and background in substance use disorder services and working knowledge of American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R). Contractor shall participate with AMH in a review of AMH provided data about the impact of these criteria on service quality, cost, outcome, and access.

(2) Contractor shall consider each eligible Member's needs and, to the extent appropriate and possible, provide specialized substance use disorder services designed specifically for the following groups as set forth in AMH administrative rules: a) adolescents, taking into consideration adolescent development, b) women, and women's specific issues, c) ethnic and racial diversity and environments that are culturally and linguistically relevant, d) intravenous drug users, e) people involved with the criminal justice system, and f) individuals with co-occurring disorders.

(3) Consistent with Exhibit B, Part 2, Section 5, Services Coordination for Non-Coordinated Care Services, Contractor shall coordinate referral and follow-up of Members to Non-Coordinated Care Services such as residential treatment services. Contractor's employees or Subcontractors providing substance use disorder services shall provide to Member, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care, elder

care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.

(4) As an alternative to Inpatient Hospital Detoxification, Contractor shall where Medically Appropriate provide medically monitored detoxification in a non-hospital based facility. Facilities or programs providing detoxification services must have a letter of approval or license form OHA.

(5) Contractor shall authorize and pay for at least culturally and linguistically appropriate outpatient substance use disorder services to eligible Members who meet ASA PPC-2R criteria for residential treatment services, when residential treatment services are not immediately available.

(6) Contractor shall require employees or Subcontractors providing substance use disorder services to provide AMH, within 30 days of admission or discharge, with all information required by AMH's most current "Client Process Monitoring System" (CPMS).

(7) Contractor shall use AMH approved substance use disorder screening tools for prevention, early detection, brief intervention and referral to substance use disorder treatment. Contractor may submit alternative screening tools to the Medicaid Substance Use Disorder specialist, AMH Medicaid Policy Unit for review and possible approval. For a list of the AMH approved screening tools, Contractor shall contact the OHP Alcohol and Drug Specialist.

(8) Contractor shall make a good faith effort to screen all eligible Members and provide prevention, early detection, brief intervention and referral to substance use disorder treatment who are in any of the following circumstances: a) at an initial contact or routine physical exam, b) at an initial prenatal exam, c) when the Member shows evidence of substance use disorder or abuse (as noted in the AMH approved screening tools), or d) when the Member over-utilizes Coordinated Care Services.

(9) Contractor shall ensure that individuals or programs have a letter of approval or license from AMH for the substance use disorder services they provide and meet all other applicable requirements of this Contract, except that providers under The Drug Addiction Treatment Act of 2000, Title 42 Section 3502 Waiver may treat and prescribe Buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.

(10) Contractor shall inform all eligible Members using culturally and linguistically appropriate means that substance use disorder outpatient, intensive outpatient and medication assisted treatment services, including opiate substitution treatment, are included in the OHP Plus and OHP Standard Benefit Package consistent with OAR 410-141-3300.

(11) Contractor shall provide covered culturally and linguistically appropriate substance use disorder services for any eligible Member who meets admission criteria for outpatient, intensive outpatient and medication assisted treatment including opiate substitution treatment, regardless of prior alcohol/other drug treatment or education.

(12) Contractor shall comply with the following access requirements: Eligible Members are seen the same day for emergency substance use disorder treatment care. Eligible Members, including pregnant women, are seen within 48 hours for urgent substance use disorder treatment care. Eligible Members, including intravenous drug users, are seen within 10 days or the Community Standard for routine substance use disorder treatment care.

(13) In addition to any other confidentiality requirements described in this Contract, Contractor shall follow the federal (42 CFR Part 2) confidentiality laws and regulations governing the identity and medical/Client records of Members who receive substance use disorder services.

(14) Contractor shall identify and ensure that Members have access to culturally and linguistically appropriate specialized programs in each Service Area in the following categories: drug court referrals, Child Welfare referrals, Job Opportunities and Basic Skills (JOBS) referrals, and referrals for persons with co-occurring disorders.

(15) Contractor shall provide Members with culturally and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education that reduces substance abuse risk to Members. Contractor's prevention program shall meet or model national quality assurance standards. Contractor shall have mechanisms to monitor the use of its preventive programs and assess their effectiveness on its Members.

n. Medication Management

(1) Except as otherwise provided in this Contract, prescription drugs are a Covered Service for funded Condition/Treatment Pairs, and Contractor shall pay for Prescription Drugs. Contractor shall provide covered prescription drugs in accordance with OAR 410-141-3070. Prescription drugs and drug classes covered by Medicare Part D for Fully Dual Eligible Clients are not a Covered Service. OHA will continue to cover selected drugs that are excluded from Medicare Part D coverage, pursuant to OAR 410-120-1210.

(2) Contractor shall develop policies and procedures to ensure children, especially those in custody of DHS, who need or who are being considered for psychotropic medications, receive medications that are for medically accepted indications. Contractor shall prioritize service coordination and the provision of other mental health services and supports for these children.

o. Intensive Case Management (Exceptional Needs Care Coordination (ENCC))

(1) Contractor is responsible for intensive case management services, otherwise known as Exceptional Needs Care Coordination (ENCC). Even if the Contractor uses another term, this section sets forth the elements and requirements for intensive case management.

(2) Contractor shall make intensive case management services available to Members identified as aged, blind, or disabled, who have complex medical needs, high health care needs, multiple chronic conditions, substance use disorder or mental illness. Intensive case management services may be requested by the Member, the Representative, Physician, other medical personnel serving the Member, or the Member's agency case manager.

(3) Contractor shall respond to requests for intensive case management services with an initial response by the next working day following the request.

(4) Contractor shall periodically inform all participating providers of the availability of intensive case management services, provide training for patient centered primary care homes and other PCP's staff on intensive case management services and other support services available for Members.

(5) Contractor shall assure that the case manager's name and telephone number are available to agency staff and Members or Representatives when intensive case management services are provided to the Member.

(6) Contractor shall make intensive case management services available to coordinate the provision of coordinated care services to Members who exhibit inappropriate, disruptive, or threatening behaviors in a Practitioner's office or clinic or other health care setting.

p. Tobacco Dependency

Contractor shall provide for: culturally and linguistically appropriate tobacco dependence Assessments, systematically and on-going; and cessation intervention, treatment, and counseling services consistent with recommendations listed in the Public Health Services Clinical Practice Guideline Treating Tobacco Use and Dependence: 2008 Update located at: http://www.ahrq.gov/path/tobacco.htm. Contractor shall make these services available to all Members assessed to use tobacco products including smokeless, dissolvable, electronic vapor, pipes and cigars. Contractor shall establish a systematic mechanism to document and report dependency and cessation services. Contractor may refer to accepted published evidence-based Community Standards, the national standard or as outlined in OAR 410-130-0190.

7. MHO Members

OHA may assign MHO Members to Contractor as limited benefit Members. Contractor shall provide to MHO Members, the benefits and covered services described in Exhibit M, which by this reference is incorporated herein, in lieu of the benefits and covered services in sections 1 through 6 of this Exhibit B, Part 2, "Benefits and Covered Services for Members."

Exhibit B –Statement of Work - Part 3 – Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement and Activation

Contractor shall actively engage Members and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of treatment plans and Member dignity is respected. Contractor shall encourage Members to be responsible and active partners in the primary care team and shall protect Members against underutilization of services and inappropriate denial of services.

Contractor shall demonstrate the means by which Contractor:

a. Uses Community input and the Community Health Assessment (CHA) process to help determine the most culturally and linguistically appropriate and effective methods for patient activation, with the goal of ensuring that Members are partners in maintaining and improving their health;

b. Engages Members to participate in the development of holistic approaches to patient engagement and responsibility that account for social determinants of health and health disparities;

c. Educates Members on how to navigate the coordinated and integrated health system developed by Contractor by means that may include Peer Wellness Specialists, Personal Health Navigators, and Community Health Workers as part of the Member's primary care team;

d. Encourages Members to make healthy lifestyle choices and to use wellness and prevention resources, including mental health and addictions treatment, culturally-specific resources provided by community based organizations and service providers;

e. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy to inform Members of rights and responsibilities;

f. Meaningfully engages the CAC to monitor patient engagement and activation.

2. Member Rights under Medicaid

Consistent with Member rights and responsibilities under Medicaid law, Contractor shall:

a. Ensure Members are aware that a second opinion is available from a qualified Health Care Professionals within the Provider Network, or that the Contractor will arrange for the Member to obtain a qualified Health Care Professionals from outside the network, at no cost to the Member.

b. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270.

c. Make oral interpretation services available free of charge to each Potential Member and Member. This applies to all non-English languages, not just those that OHA identifies as prevalent. Contractor shall notify its Members and Potential Members that oral interpretation is available for any language and that written information is available in prevalent non-English languages in Service Area(s). Contractor shall notify its Members how to access oral and written interpretation services

d. Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's plan and develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280 and 410-141-3300.

e. Allow each Member to choose his or her health professional from available Participating Providers and facilities to the extent possible and appropriate. For a Member in a Service Area serviced by only one PHP, any limitation the Contractor imposes on his or her freedom to change between PCPs may be no more restrictive than the limitation on Disenrollment under Exhibit B, Part 3, Section 4.b.(3).

f. Require, and cause its Participating Providers to require, that Members receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.

g. Allow each Member the right to be actively involved in the development of treatment plans if Covered Services are to be provided and to have Family involved in such treatment planning.

h. Allow each Member the right to request and receive a copy of his or her own Health Record, (unless access is restricted in accordance with ORS 179.505 or other applicable law) and to request that the records be amended or corrected as specified in 45 CFR Part 164.

i. Furnish to each of its Members the information specified in 42 CFR 438.10(f)(6) and 42 CFR 438.10(g), if applicable, within a reasonable time after the Contractor received notice of the Member's Enrollment from OHA or for clients who are Fully Dual Eligible, within the time period required by Medicare. Contractor shall notify all Members of their right to request and obtain the information described in this section at least once a year.

j. Ensure that each Member has the right to have access to Covered Services which at least equals access available to other persons served by Contractor.

k. Ensure Members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion.

l. Require, and cause its Participating Providers to require, that Members are treated with respect, with due consideration for his or her dignity and privacy, and the same as non-Members or other patients who receive services equivalent to Covered Services.

m. Ensure that each Member has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 -- Patient Self-Determination Act.

n. Ensure, and cause its Participating Providers to ensure, that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, its staff, Subcontractors, Participating Providers or OHA, treat the Member. Contractor shall not discriminate in any way against Members when those Members exercise their rights under the OHP.

o. Ensure that any cost sharing authorized under this Contract for Members is in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.

p. Notify Members eligible for the OHP Plus Benefit Package of their responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230.

3. Provider's Opinion

a. Members are entitled to the full range of their health care Provider's opinions and counsel about the availability of Medically Appropriate services under the OHP.

b. Contractor shall not prohibit or otherwise restrict a Health Care Professional from advising a Member who is a patient of that professional about the health status of the Member or treatment for the Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the OHP Plus or OHP Standard Benefit Package of Covered Services or if a Co-Payment may be required, if the professional is acting within the lawful scope of practice.

4. Informational Materials and Education of Members and Potential Members

a. Contractor shall have a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's integrated and coordinated care plan. Contractor shall develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280, 410-141-3300 and 42 CFR 438.10.

b. Contractor shall develop and provide written informational materials and educational programs as described in OAR 410-141-0280 and OAR 410-141-0300. These materials and programs shall be in a manner and format that may be easily understood and tailored to the backgrounds and special needs of Members and Potential Members. Contractor shall develop, and make available to its Members, a health and wellness education program that addresses Prevention and Early Intervention of illness and disease. Contractor shall distribute an approved handbook to new Members within 14 calendar days of the Member's effective date of coverage with Contractor.

c. Health education shall include: promotion and maintenance of optimal health status, to include identification of tobacco use, referral for tobacco cessation intervention (educational material, tobacco cessation groups, pharmacological benefits and the Oregon Tobacco Quit Line (1-877-270-STOP).

d. Contractor shall provide additional information that is available upon request by the Member, including information on Contractor's structure and operations, and Practitioner Incentive Plans.

e. Contractor shall ensure that all Contractor's staff who have contact with Potential Members are fully informed of Contractor policies, including Enrollment, Disenrollment, Grievance and Appeal policies and the provision of interpreter services including the Participating Provider's offices that have bilingual capacity.

f. Contractor shall furnish to each of its Members the information specified in 42 CFR 438.10(f)(6) and 42 CFR 438.10(g), if applicable, within a reasonable time after the Contractor received notice of the recipient's Enrollment from OHA or for clients who are Fully Dual Eligible, within the time period required by Medicare. Contractor shall notify all Members of their right to request and obtain the information described in this section at least once a year.

g. Contractor shall provide written notice to affected Members of any Material Change in the information described in Subsection e of this section, pertaining to program, policies and procedures that is reasonably likely to impact the affected Member's ability to access care or services from Contractor's Participating Providers. Such notice shall be provided at least 30 days prior to the intended effective date of those changes, or as soon as possible if the Participating Provider(s) has not given the Contractor sufficient notification to meet the 30 day notice requirement. OHA will review and approve such materials within two Business Days.

h. Contractor shall make its written material available in alternative formats and in an appropriate manner that takes into account the special needs of those who, for example, are visually limited or have limited reading proficiency. All Members and Potential Members must be informed that Contractor's written information is available in alternative formats and how to access those formats.

5. Grievance System

a. Contractor shall have a Grievance System, supported with written procedures, for Members that includes a Grievance process, Appeal process and access to Contested Case Hearings. Contractor's Grievance System shall meet the requirements of Exhibit I, OAR 410-141-3260 through 410-141-0266 and 42 CFR 438.402 through 438.414. The Grievance System must include Grievances and Appeals related to requests for accommodation in communication or provision of services for Members with a disability or limited English proficiency. OHA will review the Contractor's procedures for compliance and notify Contractor when approved. Upon any change to the approved procedures, Contractor shall submit the changes to OHA for approval.

6. Enrollment and Disenrollment

a. Enrollment

(1) An individual becomes a Member for purposes of this Contract as of the date of Enrollment with Contractor. As of that date, Contractor shall provide all Covered Services to such Member as required by the terms of this Contract.

(a) For persons who are enrolled on the same day as they are admitted to the hospital or, for children and adolescents admitted to psychiatric residential treatment services (PRTS), Contractor is responsible for said services.

(b) If the person is enrolled after the first day of hospital stay or PRTS, the person will be disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from hospital services or PRTS.

(2) The provisions of this section apply to all Enrollment arrangements whether Enrollment is mandatory or voluntary. If Enrollment is mandatory, OHA will sign on such individuals with a CCO selected by the individual. If an eligible individual does not select a CCO, OHA may assign the person to a CCO selected by OHA. Contractor shall have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible Clients in the order in which they apply and are signed on with Contractor by OHA, unless Contractor's Enrollment is closed under paragraph (7).

(3) Contractor shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health services, race, color, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

(4) Enrollment with Contractor may be closed by OHA, or by Contractor notifying the designated OHA CCO Coordinator, because Contractor's maximum Enrollment has been reached or for any other reason mutually agreed to by OHA and Contractor, or as otherwise authorized under this Contract or OAR 410-141-3060.

(5) If OHA enrolls a Client with Contractor in error, and the erroneously enrolled Client has not received services from Contractor, OHA may retroactively disenroll the Member from Contractor and enroll the Client with the originally intended contractor up to 60 days from the date of the erroneous Enrollment, and the Capitation Payment to Contractor will be adjusted accordingly.

(6) Contractor shall provide Enrollment validation as described in Exhibit B, Part 8, Section 7 of this Contract.

b. Disenrollment

The requirements and limitations governing Disenrollments contained in 42 CFR 438.56 and OAR 410-141-3080, Disenrollment Requirements, apply to Contractor regardless of whether Enrollment is mandatory or voluntary, except to the extent that 42 CFR 438.56(c)(2)(i) is expressly waived by CMS.

(1) An individual is no longer a Member for purposes of this Contract as of the effective date of the individual's Disenrollment from Contractor. As of that date, Contractor is no longer required to provide services to such individual by the terms of this Contract, unless the Member is hospitalized at the time of Disenrollment. In such an event, Contractor is responsible for inpatient hospital services until discharge or until the Member's PCP determines that care in the hospital is no longer Medically Appropriate. OHA will assume responsibility for other services not included in the Diagnosis Related Group (DRG) applicable to the hospitalization.

(2) If Disenrollment occurs due to an illegal act which includes Member or Provider Medicaid fraud, Contractor shall report to OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR 455.13 by one of the following methods: Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or Report fraud online at https://apps.state.or.us/cf1/OPR_Fraud_Ref/index.cfm?act=evt.subm_web

(3) A Member may be Disenrolled from Contractor as follows:

(a) If requested orally or in writing by the Member or the Member's Representative, OHA may Disenroll the Member in accordance with OAR 410-141-3000 and 410-141-3080(1)(b), OHP Disenrollment from PHPs, for the following reasons:

(i) Without cause:

(A) After six months of Member's Enrollment; or

(B) Upon automatic reenrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because he or she loses Medicaid eligibility for a period of 2 months or less), if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or

(C) Whenever the Member's eligibility is re-determined by OHA.

(ii) With cause:

(A) During the 90 days following the date of the Member's initial Enrollment with the Contractor, or the date OHA sends the Member notice of the Enrollment, whichever is later;

(B) The Member has Disenrolled from a Medicare Advantage plan;

(C) The Member receiving Medicare requests Disenrollment from Contractor which is the corresponding Medicare Advantage plan;

(D) The Contractor does not, because of moral or religious objections, cover the service the Member seeks;

(E) The Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the Contractor's network, and the Member's PCP or another Provider determines that receiving the services separately would subject the Member to unnecessary risk; or

(F) For other reasons, including but not limited to, poor quality of care, lack of access to services covered under this Contract, or lack of access to Participating Providers experienced in dealing with the Member's health care needs. Examples of sufficient cause include but are not limited to:

(I) The Member moves out of the Service Area;

(II) It would be detrimental to the Member's health to continue Enrollment;

(III) The Member is a AI/AN; or

(IV) For Continuity of Care.

The effective date of Disenrollment when requested by a Member is the first of the month following OHA's approval of Disenrollment. The effective date of Disenrollment for Members who Disenroll from Contractor's Medicare Advantage plan is the first of the month that their Medicare Advantage Disenrollment is effective. If OHA fails to make a Disenrollment determination by the first day of the second month following the month in which the Member files a request for Disenrollment, the Disenrollment is considered approved.

(4) OHA may Disenroll a Member upon request by Contractor if Disenrollment is consistent with OAR 410-141-3080, if a Member:

(a) Is unruly or abusive to others to the point that the Member's continued Enrollment in the Contractor impairs the Contractor's ability to furnish services to either this particular Member or to other Members;

(b) Threatens or commits an act of physical violence, to the point that the Member's continued Enrollment in the Contractor seriously impairs the Contractor's ability to furnish services to either the Member or other Members; or

(c) Committed fraudulent or illegal acts such as permitting the use of his or her DMAP Medical Care Identification by another person, altering a prescription, theft or other criminal acts committed in any Provider's or Contractor's premises.

Contractor submits requests for Disenrollment in writing, detailing the specific reason as required in OAR 410-141-3080 and this Contract, to their CCO Coordinator for prior approval except where otherwise specified in OAR 410-141-3080.

(5) Contractor may not request Disenrollment of a Member for reasons related to:

(a) An adverse change in the Member's health status;

(b) Utilization of health services;

(c) Diminished mental capacity;

(d) Uncooperative or disruptive behavior resulting from the Member's special needs (except when the continued Enrollment seriously impairs Contractor's ability to furnish services to either this Member or other Members);

(e) A disability or any condition that is a direct result of their disability, unless otherwise specified in OHP Administrative Rule; or

(f) Other reasons specified in OAR 410-141-3080(2)(B).

(6) The effective date of Disenrollment when requested by a Member will be the first of the month following OHA's approval of Disenrollment. The effective date of Disenrollment for Members who disenroll from Contractor's Medicare Advantage plan will be the first of the month that their Medicare Advantage Disenrollment is effective. If OHA fails to make a Disenrollment determination by the first day of the second month following the month in which the Member files a request for Disenrollment, the Disenrollment is considered approved.

(7) If OHA disenrolls a Member retroactively, OHA will recoup any CCO Payments received by Contractor after the effective date of Disenrollment. If the disenrolled Member was otherwise eligible for the OHP, services the Member received during the period of the retroactive Disenrollment may be eligible for fee-for-service payment under OHA rules.

(8) If OHA disenrolls a Member due to an OHA administrative error, and the Member has not received services from another contractor, the Member may be retroactively re-enrolled with Contractor up to 60 days from the date of Disenrollment.

(9) Disenrollment required by adjustments in Service Area or Enrollment is governed by Exhibit B, Part 3, Section 5 of this Contract.

c. Member Benefit Package Changes

The Weekly and Monthly Enrollment file (as described in Exhibit B, Part 3, Section 7 of this Contract) will identify Member's current eligibility status for either the OHP Plus or the OHP Standard Benefit Package. The file does not include any historical data on Member's eligibility status.

d. Enrollment Reconciliation

(1) Contractor shall reconcile the OHA 834 Enrollment transaction file, sent by OHA to Contractor monthly, to Contractor's current Member information in its Health Information System (HIS) for the same period (for purposes of this report refer to the previous month's data) which is known as a look back period.

(2) Contractor shall report to OHA, using the Enrollment Reconciliation Certification Forms, which are located at: found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx. Contractor's determination of OHA 834 Enrollment transaction files shall be reported as follows:

(a) If there are no discrepancies, Contractor shall complete, sign, date and submit "Enrollment Reconciliation Certification- No Discrepancies", found at the above link, to OHA within 14 calendar days of receipt of the OHA 834 Enrollment transaction file, or

(b) If there are discrepancies, Contractor shall complete, sign, date and submit, "Enrollment Reconciliation Certification - Discrepancies Found", found at the above link, to OHA within 14 calendar days of receipt of OHA's Enrollment transaction file.

(3) OHA will verify, and if applicable correct, all discrepancies reported to OHA on "Enrollment Reconciliation - Discrepancies Found", prior to the next Enrollment transaction file.

7. Identification Cards

Contractor shall provide an ID card to Members which contains simple, readable and usable information on how to access care in an urgent or emergency situation. Such ID cards confer no rights to services or other benefits under the OHP and are solely for the convenience of the Members and Providers.

8. Marketing

a. Contractor may not initiate contact or Market independently to Potential Members, directly or through any agent or independent contractor, in an attempt to influence a Client's Enrollment with Contractor, without the express written consent of OHA. Contractor may not conduct,

directly or indirectly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice the Client to enroll with Contractor, or to not enroll with another Contractor. Contractor may not seek to influence a Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Contractor shall apply the prohibitions of this paragraph to its agents, Subcontractors, and Subcontractor's agents.

b. Contractor shall provide to OHA, for approval prior to use, the form and content of all materials that reference benefits or coverage and Marketing Materials. In reviewing and approving Marketing Material, OHA will consult with a medical care advisory committee. Any Contractor representative or agent serving on the advisory committee is excused from review of Contractor's materials. Messages strictly for the purpose of health promotion, health education or outreach distributed to Contractor's existing Members do not require prior approval from OHA.

c. Contractor shall ensure that Members are not intentionally misled about their options by Contractor's staff, activities or materials. Contractor's materials may not contain inaccurate, false, confusing or misleading information.

d. Contractor shall provide copies of all written Marketing Materials to all DHS and OHA offices within Service Area(s). Contractor shall make no assertion or statement (whether written or oral) that:

(1) The Potential Member and Member must enroll with Contractor in order to obtain benefits or in order to not lose benefits; or

(2) The Contractor is endorsed by CMS, the federal or State government, or similar entity.

e. Contractor shall make information concerning Client Notices, Grievances, Appeals and Contested Case Hearings available in appropriate formats (e.g. video or audio in multiple languages) for low literacy and limited English proficient Members in all clinics, Participating Provider offices, and other service locations frequented by Members.

f. Contractor shall comply with the information requirements of 42 CFR 438.10 to ensure that, before enrolling, the Potential Member receives, from the Contractor or OHA, the accurate oral and written information he or she needs to make an informed decision on whether to enroll with the Contractor.

g. For purposes of this Section, "Cold Call Marketing," "Marketing," and "Marketing Materials" have the meanings defined in OAR 410-141-3000 or 42 CFR 438.104, whichever is broader.

1. Integration and Coordination

Contractor shall develop, implement and participate in activities supporting a continuum of care that integrates mental health, addiction treatment, dental health and physical health interventions seamlessly and holistically. Contractor understands and acknowledges that integrated care spans a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

a. Contractor shall ensure that in coordinating care, the Member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable, and consistent with other State law or Federal regulations governing privacy and confidentiality of health records.

b. Contractor shall demonstrate involvement in integration activities such as, but not limited to:

(1) Enhanced communication and coordination between Contractor and DCOs, mental health and Substance Use Disorder Providers;

(2) Implementation of integrated Prevention, Early Intervention and wellness activities;

(3) Development of infrastructure support for sharing information, coordinating care and monitoring results;

(4) Use of screening tools, treatment standards and guidelines that support integration;

(5) Support of a shared culture of integration across coordinated care plans and service delivery systems; and:

(6) Implementation of a system of care approach, incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare or Wraparound for children with behavioral health disorders.

2. Access to Care

Contractor shall provide culturally and linguistically appropriate services and supports, in locations as geographically close to where Members reside or seek services as possible, and choice of Providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to Families, diverse communities, and underserved populations.

a. Contractor shall meet, and require Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of need for services. Contractor shall comply with OAR 410-141-3220 and 410-141-3160.

b. Contractor shall ensure that Providers do not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled and shall ensure that Providers offer hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3220.

c. Contractor shall provide each Member with an opportunity to select an appropriate Mental Health Practitioner and service site.

d. Contractor may not deny Covered Services to, or request Disenrollment of, a Member based on disruptive or abusive behavior resulting from symptoms of a mental or substance use disorder or from another disability. Contractor shall develop an appropriate treatment plan with the Member and the Family or advocate of the Member to manage such behavior.

e. Contractor shall implement mechanisms to assess each Member with Special Health Care needs in order to identify any ongoing special conditions that require a course of physical health, substance use disorder, or mental health treatment or care management. The assessment mechanisms must use appropriate health care professionals.

(1) For Members with Special Health Care Needs determined to need a course of treatment or regular care monitoring, the Individual Service and Support Plan must be developed by Members PCP with Member participation and in consultation with any specialists caring for the Member; approved by Contractor in a timely manner, if approval is required; and developed in accordance with any applicable OHA quality assessment and performance improvement and utilization review standards.

(2) Based on the Assessment, Contractor shall assist Members with Special Health Care Needs in gaining direct access to Medically Appropriate care from physical health, substance use disorder or mental health specialists for treatment of the Member's condition and identified needs.

(3) Contractor shall implement procedures to share with Member's primary health care provider the results of its identification and Assessment of any Member with Special Health Care Needs so that those activities need not be duplicated. Such coordination and sharing of information must be conducted within Federal and State laws, rules, and regulations governing confidentiality.

f. Contractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to Members who have difficulty communicating due to a disability, or limited English proficiency or diverse cultural and ethnic backgrounds, and shall maintain written policies, procedures and plans in accordance with the requirements of OAR 410-141-3220.

g. Contractor shall comply with the requirement of Title II of the Americans with Disabilities Act by providing services to Members with disabilities in the most integrated setting appropriate to the needs of those Members.

h. Contractor shall ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Contractor shall include in its Grievance and Appeal procedures, described in Exhibit I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.

i. In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of this section, Contractor shall establish standards for access to Covered Services and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3220.

j. Contractor shall ensure that each Member has an ongoing source of primary care appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3120 and required by 42 CFR 438.208 (b)(1).

k. Contractor shall allow each AI/AN enrolled with Contractor to choose an Indian Health Care Provider as the Member's PCP if:

(1) An Indian Health Care Provider is participating as a PCP within the Contractor's network; and

(2) The AI/AN Member is otherwise eligible to receive services from such Indian Health Care Provider; and

(3) The Indian Health Care Provider has the capacity to provide primary health care services to such Members.

l. Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 42 CFR parts 160 and 164.

m. Contractor shall provide female Members with direct access to women's health specialists within Contractor's Participating Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCP if the designated PCP is not a women's health specialist.

n. Contractor shall provide for a second opinion from a qualified Participating Provider, which may include a qualified mental health Participating Provider if appropriate, to determine Medically Appropriate services. If a qualified Participating Provider cannot be arranged then Contractor shall arrange for the Member to obtain the second opinion from a Non-Participating Provider, at no cost to the Member.

3. Delivery System and Provider Capacity

a. Delivery System Capacity

(1) As specified in 42 CFR 438.206, Contractor shall maintain and monitor a Participating Provider Panel that is supported with written agreements (as specified in Exhibit D, Section 18 and Exhibit B, Part 4, Section 7), and has sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to Covered Services to Members across the age span from child to older adult, including Members who are dually eligible for Medicare and Medicaid. In establishing and maintaining the Provider Panel, Contractor shall consider, at a minimum, the following:

(a) The anticipated Medicaid Enrollment and anticipated Enrollment of individuals dually eligible for Medicare and Medicaid;

(b) An appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled in the Service Area;

(c) The expected utilization of Services, taking into consideration the characteristics and behavioral health care needs of Members;

(d) The number and types (in terms of training, experience, and specialization) of Providers required to provide services under this Contract;

(e) The geographical location of Participating Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members and whether the location provides physical access for Members with disabilities;

(f) The network of Providers is sufficient in numbers and areas of practice and geographically distributed in a manner that the health services provided under this Contract are reasonably accessible to Members, as stated in ORS 414.736;

(g) The number of Providers who are not accepting new Members; and

(h) Contractor's approach to integrated care and care coordination and the use of patient-centered primary care homes.

(2) Contractor shall allow each Member to choose a Provider within Contractor's Provider Network to the extent possible and appropriate.

(3) Contractor shall provide Members with access, as Medically Appropriate, to licensed medical professionals and addictions and mental health providers.

(4) Contractor shall demonstrate that the number of Indian Health Care Providers that are Participating Providers are sufficient to ensure timely access to Covered Services within the scope of Covered Services specified under this Contract, for those AI/AN enrolled with the Contractor who are eligible to receive services from such providers, or shall demonstrate that there are no or few Indian Health Care Providers in the Service Area(s).

(5) Contractor shall identify training needs of its Provider Network and shall address such needs to improve the ability of the Provider Network to deliver Covered Services to Members.

(6) If Contractor is unable to provide necessary Covered Services which are culturally and linguistically and Medically Appropriate to a particular Member within its Provider Panel, Contractor shall adequately and timely cover these services out of network for the Member, for as long as Contractor is unable to provide them. Out of network providers must coordinate with Contractor with respect to payment. Contractor shall ensure that cost to Member is no greater than it would be if the services were provided within the Provider Panel.

(7) Contractor shall participate in OHA efforts to promote the delivery of services in a Culturally Competent manner to Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

(8) Contractor shall coordinate its service delivery system planning effort with organized planning efforts carried out by the local mental health authority in its Service Area.

b. Provider Capacity

(1) Contractor shall maintain and monitor a network of Participating Providers that is supported with written agreements (as specified in Exhibit D, Section 18 and Exhibit B, Part 4, Section 7, while providing timely and Medically Appropriate Covered Services for Members as required by this Contract and under OAR 410-141-3120. Contractor shall establish written policies and procedures in place which comply with the CCO rule for credentialing and recredentialing, OAR 410-141-3120, and the requirements specified in 42 CFR 438.214, which include selection and retention of Providers, credentialing and re-credentialing requirements, and nondiscrimination. In establishing and maintaining the network, Contractor shall:

(a) Complete the Provider Capacity Report as required in Exhibit G as specified in Exhibit B, Part 4, Section 1, Subsection (4) and submit to OHA an update of this Provider Capacity Report at any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services, including the Enrollment of a new population or any time it enters into a contract with OHA;

(b) Use Provider selection policies and procedures, in accordance with 42 CFR 438.12 and 42 CFR 438.214, that do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. If Contractor 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;

(c) Consider the number of Participating Providers who are not accepting new Members; and

(d) Demonstrate that the number of Indian Health Care Providers that are Participating Providers are sufficient to ensure timely access to Covered Services for those AI/AN enrolled with the Contractor who are eligible to receive services from such providers, or demonstrate in the Service Areas that there are no or few Indian Health Care Providers.

4. Delivery System Features

Contractor shall ensure that Members have access to high quality, appropriately integrated and coordinated care and services, through a Provider Network capable of meeting Health System Transformation objectives. Contractor shall operate a transformed delivery system that accomplishes the following:

a. Patient-Centered Primary Care

Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of health system transformation. In this connection, Contractor shall:

(1) Contract with a network of PCPCHs recognized under Oregon's standards. Contractor shall provide:

(a) Assurances that the Contractor enrolls a significant percentage of Members in PCPCHs certified as Tier 1 or higher according to Oregon's standards; and

(b) A concrete plan for increasing the number of enrollees served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and

(c) A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks.

Require Contractor's other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available.

(2) Ensure that Members of all communities in Service Area receive integrated, culturally and linguistically appropriate person-centered care and services, and that Members are fully informed partners in transitioning to and maximizing the benefits of this model of care.

(3) Encourage the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations.

b. Care Coordination

(1) Contractor shall provide following elements of care coordination:

(a) Contractor shall support the appropriate flow of relevant information; identify a lead Provider or care team to manage Member care and coordinate all Member services; and, in the absence of full health information technology capabilities, implement a standardized approach to effective transition planning and follow-up.

(b) Contractor shall work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded LTC services and mental health crisis management services.

(c) Contractor shall develop culturally and linguistically appropriate tools for provider use to assist in the education of Members about roles and responsibilities in communication and care coordination.

(d) Contractor shall coordinate with DHS Medicaid-funded long term care providers and local long term care office(s) in their service area for their Members receiving DHS Medicaid-funded long term care services.

(e) Contractor shall coordinate with residential addictions and mental health services providers for their Members receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services.

(f) Contractor shall coordinate with state institutions and other mental health hospital settings to facilitate Member transition into the most appropriate, independent, and integrated community-based settings.

(2) Contractor shall use evidence-based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness or other chronic conditions who receive home and community based services under the State's 1915(i) State Plan Amendment, as follows:

(a) Assignment of responsibility and accountability: Contractor shall document that each Member has a PCP or primary care team that is responsible for coordination of care and transitions.

(b) Individual care plans: Contractor shall use individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health needs. Contractor shall ensure that individual care plans developed for Members reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.

(c) Communication: Contractor shall encourage Providers to have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion.

(3) Contractor shall develop a coordinated and integrated Provider Network that demonstrates communication, collaboration and shared decision making across relevant Providers and care settings. Contractor shall demonstrate the ability to:

(a) Ensure a network of Providers to serve Members' health care and service health, meet access-to-care standards, and allow for appropriate choice for Members. Services and supports must be as geographically available as possible and, to the extent necessary, offered in nontraditional integrated settings that are accessible to families, socially, culturally, and linguistically diverse communities, and underserved populations.

(b) Build on existing Provider Network and transforms them into a patient-centered, integrated, and coordinated delivery system including arrangements with external providers necessary to assure access to the full range of Medicaid services.

(c) Develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in Service Area(s), and participate in the coordination and integration of care agreements these partners.

c. Care Integration

Contractor shall ensure the provision of the following elements of Care Integration:

(1) Mental Health and Substance Use Disorder Treatment: Outpatient mental health and substance use disorder treatment shall be integrated into the person-centered care model and delivered through and coordinated with physical health care services by Contractor and by Contractor's transformed health system.

(2) Oral Health: By July 1, 2014, Contractor shall have a formal contractual relationship with any DCO that serves Members in Service Area.

(3) Hospital and Specialty Services: Contractor shall provide adequate, timely and appropriate access to specialty and hospital services. Contractor's service agreements with specialty and hospital providers shall address the coordinating role of patient-centered primary care; shall specify processes for requesting hospital admission or specialty services; and shall establish performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. Contractor shall demonstrate how hospitals and specialty service providers are accountable for achieving successful transitions of care. Contractor shall ensure that primary care teams transition Members out of hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as Hospice and other palliative care settings.

d. Contractor shall document its methods and findings to ensure across the organization and the network of providers there is documentation of the following features of the delivery system:

(1) Each Member has access to a consistent and stable relationship with a care team that is responsible for comprehensive care management and transitions.

(2) The supportive and therapeutic needs of the Member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.

(3) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(4) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources.

(5) Members have access to advocates such as qualified Peer Wellness Specialists, Personal Health Navigators, or qualified Community Health Workers who may be part of the Member's care team.

(6) Members are encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

5. Delivery System Dependencies

a. Shared Accountability for DHS Medicaid-funded Long-term Care Services

To ensure delivery of high quality, person-centered care, Contractor will be held accountable (as described under Exhibit B, Part 9, Section 3) for its performance on a subset of CCO core accountability metrics (identified under Exhibit B, Part 9, Section 4) for its Members receiving DHS Medicaid-funded long term care services.

b. Intensive Care Coordination for Special Health Members

(1) Contractor shall prioritize working with Members who have high health care needs, multiple chronic conditions, mental illness or substance use disorder and communities experiencing health disparities (as identified in the community health assessment). Contractor shall actively engage those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(2) Contractor shall provide intensive care coordination or Case Management Services to Members who are aged, blind, disabled or who have complex medical health consistent with ORS 414.712, including Members with mental illness and Members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) State Plan Amendment.

(3) Contractor shall implement procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled (including mental illness or substance abuse disorders) or having complex medical health needs with Participating Providers serving the Member so that those activities need not be duplicated. Contractor shall create procedures and share information under ORS 414.679 in compliance with the confidentiality requirements of this Contract.

(4) Contractor shall establish policies and procedures, including a standing referral process for direct access of specialists, for identifying, assessing and producing a treatment plan for each Member identified as having a special healthcare need. Contractor shall ensure that each treatment plan:

(a) Is developed by the Member's designated Practitioner with the Member's participation;

(b) Includes consultation with any specialist caring for the Member;

(c) Is approved by the Contractor in a timely manner, if this approval is required; and

(d) Accords with any applicable State quality assurance and utilization review standards.

c. State and Local Government Agencies and Community Social and Support Services Organizations

Contractor shall promote communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, behavioral health and public health, as critical for the development and operation of an effective Delivery System Network (DSN). Contractor shall consult and collaborate with Contractor DSN Providers to maximize Provider awareness of available resources to ensure diverse Members' health, and to assist DSN Providers to be able to make referrals to the appropriate providers or organizations. Contractor shall ensure that the assistance that Contractor provides to DSN Providers in making referrals to State and local governments and to community social and support services organizations takes into account the following referral and service delivery factors identified in the Community health Assessment and Community Improvement Plan.

d. Cooperation with Dental Care Organizations

Contractor shall coordinate preauthorization and related services with DCOs to ensure the provision of dental care to be performed in an outpatient hospital or ASC in cases in which the age, disability, or medical condition of the Member necessitates providing services in an outpatient hospital or ASC.

e. Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes

Contractor shall arrange to provide medication, as covered under Contractor's global budget, to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility's delivery, dosage and packaging requirements and Oregon law.

6. Evidence-Based Clinical Practice Guidelines

Contractor shall adopt practice guidelines, specified in 42 CFR 438.236 (b), (c) and (d), that are based on valid and reliable clinical evidence or a consensus of healthcare professionals and that consider the needs of Members. Contractor shall adopt these practice guidelines in consultation with Contractor's Participating Providers and shall review and update them periodically as appropriate. Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Potential Members, Members or Representatives. Contractor's decisions for utilization management, Member education, coverage of services, or other areas to which the guidelines apply, must be consistent with the adopted practice guidelines.

7. Health Promotion and Prevention

Contractor shall provide evidence-based care in a culturally and linguistically appropriate manner that supports prevention, contains cost, and improves health outcomes and quality of life for their Members. Contractor shall report to OHA on health promotion and disease prevention, describing the means by which Contractor will accomplish the following tasks. Contractor shall:

a. Collect data for Member population service planning and delivery, reported with consideration to implementing state plans for achieving public health objectives and meeting national Healthy People 2020 objectives and Meaningful Use standards.

b. Provide appropriate health risk assessment for Members. Assessment may be provided or coordinated through a Members' Patient-Centered Primary Care Home. These assessments will include screening for chronic disease and risk factors such as alcohol, tobacco use and other substance use, high blood pressure, diabetes, depression, breast, colorectal and cervical cancer, high cholesterol, stress, trauma and other mental health issues with opportunities for education, treatment and follow-up based on results.

c. Actively promote all health screening methodologies receiving a Grade A or B recommendation by the US Preventive Services Task Force to patients, families, and providers..

d. Actively promote screenings recommended by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev.) (1994; 2000; 2002) for pediatric populations to patients, families, and providers.

e. Demonstrate evidence of partnership with health promotion and local prevention leaders and professionals, including local public health authorities.

f. Contribute to implementation of the State's comprehensive plans for promotion of physical activity and healthy nutrition, tobacco prevention and older adult and youth suicide prevention.

g. Contribute to local public health and health promotion planning efforts.

h. Meet the needs of culturally and linguistically diverse communities and specify the actions Contractor will take to reduce or eliminate health disparities.

i. Disseminate culturally and linguistically appropriate educational materials that meet Members diverse health literacy needs on healthy lifestyles and chronic disease early detection, treatment and self-management at plan and provider levels (provider/hospital Meaningful Use optional criteria).

j. Assure full compliance with disease reporting to the public health system.

k. Coordinate the above activities with Members' Patient-Centered Primary Care Home or PCP.

8. Health Leadership Council High Value Medical Home – only for PacificSource

Contractor shall cooperate with these designated Patient Centered Medical Homes (PCMHs) as follows:

a. OHA shall pay Contractor a PCMH reimbursement payment in addition to the CCO Payment in accordance with the CCO Payments calculation reflected in the rate schedule in Exhibit C, Attachment 2. OHA will from time to time determine the PCMH reimbursement payment for each PCMH clinic designated by OHA, in an amount not to exceed $45 per Member assigned to PCMH per month.

b. Contractor shall distribute all PCMH reimbursement payment amounts to eligible clinics, designated by OHA, located in the State that receive PCMH reimbursement payment determined by Enrollment of designated high risk Members, in accordance with requirements established by OHA, for services outside the scope of services for which Contractor is compensated by the CCO Payments.

c. Contractor shall submit to OHA all Claims, financial and other required data elements within 45 days from the Date of Service.

9. Patient Centered Primary Care Homes (PCPCH)

Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes recognized by the OHA. Contractor shall provide support for moving providers along the spectrum of the PCPCH model (from Tier 1 to Tier 3). Contractor shall assist Providers within its delivery system to establish PCPCHs.

The following provisions are based on CMS approval of Oregon's PPACA Section 2703 Medicaid State Plan Amendment (SPA) and additional related state plan changes needed for federal authorization to implement Oregon's Patient Centered Primary Care Home model in the Medicaid program.

a. When CMS has approved Oregon's PPACA SPA, OHA will provide Contractor payments in addition to capitation, for Members with chronic conditions (as defined in Oregon's Medicaid state Plan Amendment 2703 and as specified in OAR 410-141-0860) ("ACA Qualifying Conditions") consistent with CMS approval. For Members that have ACA qualifying conditions, Contractor shall provide enhanced or additional reimbursement for PCPCH services and should reflect the PCPCH Tier level achieved, consistent with CMS approvals.

b. If Contractor retains any portion of the PCPCH case rate payment for individuals with ACA Qualifying conditions and does not pass the entire payment to the Provider, Contractor shall use that portion to carry out functions related to PCPCH and is subject to approval by OHA.

c. In addition to Provider reporting requirements described in OARs, Contractor shall provide a report to OHA on a monthly basis to include all Members with chronic conditions, as described in the CMS approved State Plan amendment, that are assigned to a PCPCH Provider listed out by tier 1, 2 or 3. Contractor should work with each PCPCH Provider in developing these lists.

d. Contractor shall provide a report to OHA that includes the following:

(1) Number of health care teams or clinics meeting PCPCH standards, by tier.

(2) Number of primary care Practitioners accepting Members in a PCPCH listed out by tier 1, 2 or 3.

(3) Number of Members assigned to Providers in PCPCH practices listed out by tier 1, 2 or 3.

(4) Number of Members with chronic conditions, as described in the CMS approved State Plan Amendment, listed out by tier 1, 2 or 3.

e. Contractor shall promote and assist other Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

f. The payment methodology and reporting requirements contained in this section will be revisited and are subject to amendment effective October, 2013.

10. Subcontract Requirements

Contractor ensures that Subcontracts executed with Providers seek to apply best practices in the management of its Provider Network. The requirements of this section do not prevent the Contractor from including additional terms and conditions in its subcontracts to meet the legal obligations or system requirements of the Contractor. Contractor ensures that the following standards are included in its Subcontracts:

a. General Standards

Contractor shall ensure that all subcontracts are in writing, specify the subcontracted Work and reporting responsibilities, meet the requirements described below and any other requirement as described throughout this Contract, and incorporate portions of this Contract, as applicable, based on the scope of Work to be subcontracted. Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(1) Subject to the provisions of this section, Contractor may subcontract any or all of the Work to be performed under this Contract. No Subcontract may terminate or limit Contractor's legal responsibility to OHA for the timely and effective performance of Contractor's duties and responsibilities under this Contract. Any and all Corrective Action, sanctions, recovery amounts and/or enforcement actions are solely the responsibility of the Contractor.

(2) The following requirements of this Contract may not be subcontracted:

(a) Oversight and monitoring of Quality Improvement activities; and

(b) Adjudication of final Appeals in a Member Grievance and Appeal process.

(3) Contractor shall negotiate a rate of reimbursement with Fully Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) that is not less than the level and amount of payment which the Contractor would make for the same service(s) furnished by a Provider, which is not a FQHC or RHC consistent with the requirements of 42 USC §1396b (m)(2)(A)(ix) and BBA 4712(b)(2);

(4) Contractor shall ensure that Subcontractors and Providers do not bill Members for services that are not covered under this Contract unless there is a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

(5) Contractor shall provide every Subcontractor, at the time it enters into a subcontract, its OHA approved written procedures for its Grievance System.

(6) Contractor shall monitor the Subcontractor's performance on an ongoing basis and perform at least once a year a formal review of compliance with delegated responsibilities and Subcontractor performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230. Upon identification of deficiencies or areas for improvement, Contractor shall cause Subcontractor to take Corrective Action and shall notify the Contract Administrator of the Corrective Action.

(7) Contractor's agreement with the Subcontractor shall:

(a) Provide for the termination of the Subcontract or imposition of other sanctions by Contractor if the Subcontractor's performance is inadequate to meet the requirements of this Contract; and

(b) Require Subcontractor to comply with the requirements of 42 CFR 438.6 that are applicable to the Work required under the subcontract; and

(c) Require Subcontractor to comply with all the requirements of Exhibit B, Part 8, Section 12 and Section 13."

(8) Contractor shall provide Members written notice of termination of any Subcontractor, within 15 days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Subcontractor.

(9) Contractor shall meet, and require its Participating Providers to meet, OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220. This requirement includes the Participating Providers offering hours of operation that are not less than the hours of operation offered to Contractor's commercial Members (as applicable).

11. Adjustments in Service Area or Enrollment

a. If Contractor experiences a Material Change, or is engaged in the termination or loss of a Provider or group or affected by other factors which have significant impact on access in that Service Area and which may result in transferring a substantial number of Members to other Providers employed or subcontracted with Contractor, Contractor shall provide OHA with a written plan for transferring the Members and an updated Provider Report, Exhibit G, at least 90 days prior to the date of such action, notwithstanding the Contract renewal date. Contractor shall remain responsible for maintaining sufficient capacity and solvency, and providing all Coordinated Care Services through the end of the 90-day period.

(1) If Contractor must terminate a Provider or group due to circumstances that could compromise Member care, less than the required notice to OHA may be provided with the approval of OHA.

(2) If a Provider or group terminates its subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required 90 days notice, less than the required notice to OHA may be provided with the approval of OHA.

(3) If Contractor cannot demonstrate sufficient Provider capacity, OHA may seek other avenues to provide services to Members. If OHA determines that some or all of the affected Members must be disenrolled from Contractor, the applicable provisions of this Section shall apply.

b. If Contractor experiences a Material Change, or is engaged in the termination or loss of a Provider or group or affected by other factors which has significant impact on access in that Service Area and which may result in reducing or terminating Contractor's Service Area or disenrolling a substantial number of Members from Contractor, Contractor shall provide OHA

with a written notice and a plan for implementation (which may include an intent to transfer its Members in the Service Area to a Contractor designated by OHA) at least 90 days prior to the date of such action, notwithstanding the Contract renewal date. Contractor shall remain responsible for providing all Coordinated Care Services through the end of the 90-day period, without limitation, for all Members for which the Contractor received a CCO Payment.

(1) If Contractor must terminate a Provider or group due to circumstances that could compromise Member care, less than the required notice to OHA may be provided with the approval of OHA.

(2) If a Provider or group terminates their Subcontract or employment with Contractor or Contractor is affected by other circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required 90 days notice, less than the required notice to OHA may be provided with the approval of OHA.

(3) If Contractor provides OHA with the required 90-day notice but provides no Letter of Intent to transfer its Members to a designated Contractor within 30 days of the 90-day notice, Members in the affected Service Area will be disenrolled from Contractor and will be assigned to existing Contractors providing services in the affected Service Area(s) who can demonstrate Provider capacity.

(4) If Contractor provides OHA with the required 90-day notice and also provides a Letter of Intent to transfer its Members to a designated Contractor, and OHA determines that the designated Contractor(s) will have sufficient Provider capacity as of the date of the proposed transfer, OHA may approve the Disenrollment and transfer of Members and develop such Contract amendment(s) as may be necessary to effect the transfer.

(5) OHA may seek other avenues to provide services to the Members in the affected area(s).

c. If Members are required to disenroll from Contractor pursuant to this Section 2, Contractor remains responsible for all Coordinated Care Services, without limitation, for each Member until the effective date of Disenrollment. Unless specified otherwise by OHA, Disenrollments shall be effective the end of the month in which the Disenrollment occurs. Contractor shall cooperate in notifying the affected Members and coordinating care and transferring records during the transition to the designated contractor or to the contractor that has been assigned to the Member or to such other PCP as may be designated. If OHA must notify affected Members of the change, Contractor shall provide OHA with the name, prime number, and at least one address label for each of the affected Members not less than 45 days prior to the effective Disenrollment date.

d. Contractor shall complete submission and corrections to encounter data for services received by Members; shall assure payment of valid claims by employees and Subcontractors, and for Non-Participating Providers providing Covered Services to Members; and shall comply with the other terms of this Contract applicable to the dates of service before Disenrollment of Members pursuant to this section. OHA may, in its discretion, withhold 20% of Contractor's CCO Payment until all contractual obligations have been met to OHA's satisfaction. Contractor's failure to complete or ensure completion of said contractual obligations within a reasonable period of time will result in a forfeiture of the amount withheld.

e. If Contractor is assigned or transferred Clients pursuant to Subsections b. or c. of this section, Contractor accepts all assigned or transferred Clients without regard to the Enrollment exemptions in OAR 410-141-3060.

f. If this Contract is amended to reduce the Service Area and/or to reduce the Enrollment limit, the CCO Payment rates may be recalculated using the methodology described in Exhibit C, Attachment 1, as follows:

If the calculation based on the reduced Service Area and/or Enrollment limit would result in a rate decrease, this Contract will be amended to reduce the amount of the CCO Payment rates in Exhibit C, Attachment 2, effective the date of the reduction of the Service Area and/or Enrollment limit.

g. If this Contract is amended to expand the Service Area and/or the Enrollment limit, the CCO Payment rates may be recalculated using the methodology described in Exhibit C, Attachment 1, as follows:

(1) If the calculation based on the expanded Service Area and/or Enrollment limit would result in a rate increase, this Contract will be amended to increase the amount of the CCO Payment rates in Exhibit C, Attachment 2, effective the date of the expansion of the Service Area and/or Enrollment limit.

(2) If the calculation based on the expanded Service Area and/or Enrollment limit would result in a rate decrease, Contractor's rates will be amended to adjust the rates when the next OHP-wide rate adjustment occurs.

Exhibit B –Statement of Work - Part 5 – Health Equity and Elimination Health Disparities

Contractor shall demonstrate how it will carry out health improvement strategies to eliminate health disparities and improve the health and well-being of all Members.

Contractor shall collect and maintain race, ethnicity, and primary language data, including mental health and substance abuse disorder data, for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor shall track and report on any quality performance improvements and outcome measures by these demographic factors and develops, implements, and evaluates strategies to improve health equity and address health disparities. OHA data collected about Member race, ethnicity and primary language data will fulfill Contractor's responsibility for collecting that specific data.

Contractor shall partner with local public health and culturally, linguistically and demographically diverse community partners to address the causes of health disparities.

Exhibit B –Statement of Work - Part 6 – Payment Methodologies That Support the Triple Aim

Contractor shall demonstrate how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for Members.

Contractor shall define its schedule for Contractor implementation of alternative payment methodologies, with benchmarks and evaluation points identified. Contractor shall assign a high priority to payments to Patient-Centered Primary Care Homes for individuals with chronic conditions. Contractor shall develop a protocol for ensuring prompt payments to payments to Patient-Centered Primary Care Homes for implementation in the first year of Contractor operations.

Contractor's alternative payment methodologies shall comply with requirements under law and rule, and with Health System Transformation objectives including:

1. Ensuring that Contractor pays hospitals other than Type A and B Rural hospitals using Medicare-like payment methodologies that pay for bundles of care rather than paying a percentage of charges.

2. Ensuring that Contractor does not pay any provider for services rendered in a facility if the condition being treated is a health care acquired condition for which Medicare would not pay the facility.

3. In addition to the base CCO Payment rate paid to Contractor, OHA pays a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in the Core Contract. Contractor shall distribute such hospital reimbursement adjustment amounts to eligible hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups (DRGs), in accordance with requirements established by OHA.

4. Ensuring that Contractor or its Subcontractors is responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Subcontractors under this Contract.

Exhibit B –Statement of Work - Part 7 – Health Information Systems

1. Contractor shall maintain a health information system that meets the requirements of this Contract, as specified in 42 CFR 438.242 and that will collect, analyze, integrate and report data that can provide information on areas including but not limited to:

a. Names and phone numbers of the Member's Primary Care Physician or clinic, primary Dentist and mental health Practitioner;

b. Copies of Client Process Monitoring System (CPMS) Enrollment forms;

c. Copies of long term psychiatric care determination request forms;

d. Evidence that the Member has been informed of rights and responsibilities;

e. Grievance, Appeal and hearing records;

f. Utilization of services;

g. Disenrollment for other than loss of Medicaid eligibility;

h. Coordinated Care Services provided to Members, through encounter data system or other documentation system; and

i. Member characteristics, including but not limited to race, ethnicity and preferred language in accordance with OHA and DHS standards.

2. Contractor shall collect data at a minimum on:

a. Member characteristics and provider characteristics as required in Exhibit G;

b. Member Enrollment; and

c. Services provided to Members for pharmacy, and encounter data reporting.

3. Contractor shall ensure Claims data received from Providers, either directly or through a third party submitter, is accurate, truthful and complete in accordance with OAR 410-141-3320 and OAR 410-120-1280 by:

a. Verifying accuracy and timeliness of reported data;

b. Screening data for completeness, logic and consistency;

c. Submitting the certification contained in Exhibit B, Part 8, Section 7;

d. Collecting service information in standardized formats to the extent feasible and appropriate, if HIPAA standard Contractor must utilize the HIPAA standard including OHA Electronic Data Transmission (EDT) procedures; and

e. Confirming Member's responsibility for its portion of payment as stated in 42 CFR 438.10

4. Contractor shall make all collected and reported data available upon request to OHA and CMS (as specified in 42 CFR 438.242).

5. Electronic Health Information

Contractor shall demonstrate how it will achieve minimum standards in foundational areas of health information technology (HIT) such as electronic health records and health information exchange, and shall develop its own goals for transformational elements of HIT such as analytics, quality reporting, and patient engagement.

a. Electronic Health Records Systems (EHRs)

Contractor shall facilitate Providers' adoption and meaningful use of EHRs. In order to facilitate EHR adoption and meaningful use, Contractor shall:

(1) Identify provider network EHR adoption rates; rates may be identified by provider type and/or geographic region;

(2) Develop and implement strategies to increase adoption rates of certified EHR; and

(3) Encourage EHR adoption.

b. Health Information Exchange (HIE)

Contractor shall facilitate electronic health information exchange in a way that supports exchange of patient health information among Participating Providers to transform from a volume-based to a value-based delivery system. In order to do so, Contractor shall initially identify current capacity and shall develop and implement a plan for improvement (including benchmarks and evaluation points) in the following areas:

(1) Analytics used in reporting outcomes measures to Contractor's provider network to assess indicators such as provider performance, effectiveness and cost-efficiency of treatment;

(2) Quality Reporting to support Quality Improvement within Contractor's provider panel and to report the data on quality of care necessary for OHA to monitor Contractor's performance;

(3) Patient engagement through HIT, such as using e-mail; and

(4) Other HIT.

Exhibit B –Statement of Work - Part 8 – Operations

1. Accountability and Transparency of Operations

a. Contractor shall use best practices in the management of finances, contracts, claims processing, payment functions and provider networks consistent with ORS 414.625.

b. Contractor and its Subcontractors shall provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with this Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.

c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures determined appropriate for evaluating CCO progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of patient centered primary care homes, the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA, CMS or external review organizations.

d. Contractor shall, based on written policies and procedures, develop and maintain a record keeping system that:

(1) Includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the Member; and

(2) Conforms to accepted professional practice; and

(3) Allows the Contractor to ensure that data received from Providers is accurate and complete by:

(a) Verifying the accuracy and timeliness of reported data;

(b) Screening the data for completeness, logic, and consistency; and

(c) Collecting service information in standardized formats to the extent feasible and appropriate.

e. Contractor shall ensure that the record keeping systems of its Participating Providers conform to the standards of Paragraph d.

f. Contractor shall review all internal policies and procedures on a biennial basis. Contractor shall submit timely, accurate and complete reports to OHA as Contractor may be notified in writing by OHA. OHA will from time to time post on its web site information about required reports, include the type of report, location in Contract, due date, and to whom submitted.

g. Contractor's failure to submit data, provide access to records or facilities, participate in consumer surveys or other accountability requirements in accordance with this Contract is noncompliance with the terms of this Contract and is grounds for sanction as specified in Exhibit D, Section 31 through 35.

2. Privacy, Security and Retention of Records

a. Maintenance and Security: Contractor shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC ¦ 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the Coordinated Care Services received by the Members. Contractor shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Contractor shall document all monitoring and Corrective Action activities. Such policies and procedures must ensure that records are secured, safeguarded and stored in accordance with applicable ORS 413-171; ORS 414.679; SB 1580, Section 16; OAR 410-120-1360; OAR 943-014-0300 through 943-014-0320; and OAR 943-120-0000 through 943-120-0200.

b. Members must have access to the Member's personal health information in the manner provided in 45 C.F.R. 164.524 and ORS 179.505(9) so the Member can share the information with others involved in the Member's care and make better health care and lifestyle choices. Contractor and PHP's Participating Providers may charge the Member for reasonable duplication costs when the Member seeks copies of their records.

c. Notwithstanding ORS 179.505, Contractor, its provider network and programs administered by OHA and DHS may use and disclose Member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the Members.

d. Contractor and its provider network may use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the Contractor for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the Contractor and the Contractor's providers for purposes unrelated to this section or the requirements of ORS 414.625, 414.632, 414.635, 414.638, 414.653 or 414.655 remains subject to any applicable federal or state privacy requirements.

e. Contractor and the Contractor's provider network may disclose information about Members to the OHA and DHS for the purpose of administering the laws of Oregon.

f. Access to Records: Contractor shall cooperate with DMAP, AMH, the Department of Justice Medicaid Fraud Unit, and CMS, or other authorized state or federal reviewers, for the purposes of audits, inspection and examination of Members' Clinical Records, whether those records are maintained electronically or in physical files. Documentation must be sufficiently complete and accurate to permit evaluation and confirmation that Coordinated Care Services were authorized and provided, referrals made, and outcomes of coordinated care and referrals sufficient to meet

professional standards applicable to the Health Care Professional and to meet the requirements for health oversight and outcome reporting in these rules.

g. Retention of Records: Contractor shall retain Clinical Records for seven years after the Date of Services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, Contractor shall retain the Clinical Records until all issues arising out of the action are resolved.

h. Public Records Law

Contractor understands that information prepared, owned, used or retained by OHA is subject to the Public Records Law, ORS 192.410 et. seq.

3. Payment Procedures

a. Contractor shall pay for all Covered Services to Members and may require, except in an emergency that Members obtain such Covered Services from Contractor or Providers affiliated with Contractor in accordance with OAR 410-141-0420 Billing and Payment.

b. Contractor shall ensure that neither OHA nor the Member receiving services are held liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise.

c. Except as specifically permitted by this Contract including TPR recovery, Contractor and its Subcontractors may not be compensated for Work performed under this Contract from any other department of the State, nor from any other source including the federal government.

d. Contractor shall comply with Section 6507 of the Patient Protection and Affordable Care Act (PPACA) regarding the use of National Correct Coding Initiative (NCCI).

e. Contractor shall comply with PPACA Section 6402 and the False Claims Act which obligates Contractor to notify OHA of the existence of an overpayment within 60 days of identifying an overpayment.

f. Certain federal laws governing reimbursement of Federally Qualified Health Centers, Rural Health Centers and Indian Health Care Providers may require OHA to provide supplemental payments to those entities, even though those entities have subcontracted with Contractor to provide Covered Services and including Indian Health Care Providers that do not have a subcontract with the Contractor. These supplemental payments are outside the scope of this Contract and do not violate the prohibition on dual payment contained herein. Contractor shall maintain encounter data records and such additional Subcontract information documenting Contractor's reimbursement to Federally Qualified Health Centers, Rural Health Centers and Indian Health Care Providers, and to provide such information to OHA upon request. Contractor shall provide information documenting Contractor's reimbursement to non-participating Indian Health Care Providers to OHA upon request.

4. Claims Payment

a. Claims that are subject to payment under this Contract by Contractor from Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280, 410-120-1295 and 410-120-1300. Contractor shall pay Non-Participating Providers for Covered Services, consistent with the provisions of ORS 414.743, OAR 410-120-1340 and OAR 410-141-3420.

b. Contractor may require Participating Providers to submit all billings for Members to Contractor within four months of the date of service, except under the following circumstances:

(1) Billing is delayed due to eligibility issues;

(2) Pregnancy of the Member;

(3) Medicare is the primary payer;

(4) Cases involving third party resources;

(5) Covered Services provided by Non-Participating Providers that are enrolled with OHA; or

(6) Other circumstances in which there are reasonable grounds for delay (which does not include a Subcontractor's failure to verify Member eligibility).

c. Contractor shall have written procedures for processing Claims submitted for payment from any source. The procedures shall specify time frames for and include:

(1) Date stamping Claims when received;

(2) Determining within a specific number of days from receipt whether a Claim is valid or non-valid;

(3) The specific number of days allowed for follow up of pended Claims to obtain additional information;

(4) The specific number of days following receipt of additional information that a determination must be made;

(5) Sending notice of the decision with Appeal rights to the Member when the determination is made to deny the Claim;

(6) Making Appeal rights available upon request to a Member's authorized Representative who may be either a Participating Provider or a Non-participating Provider when the determination is made to deny a Claim for payment; and

(7) The date of payment, which is the date of the check or date of other form of payment.

d. Contractor shall pay or deny at least 90% of Valid Claims within 45 days of receipt and at least 99% of Valid Claims within 60 days of receipt. Contractors shall make an initial determination on 99% of all Claims submitted within 60 days of receipt. The date of receipt is the date the

Contractor receives the Claim, as indicated by its date stamp on the Claim. Contractor and its Subcontractors may, by mutual agreement, establish an alternative payment schedule not to exceed the minimum requirements.

e. Claims that are subject to payment under this Contract by Contractor from Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280 and 410-120-1300. If a Provider is not enrolled with OHA on the date of service, but the Provider becomes enrolled pursuant to OAR 410-120-1260(6) "Provider Enrollment", the Claim shall be processed by Contractor as a Claim from a Non-Participating Provider. Payment of Non-Participating Providers shall be consistent with the provisions of OAR 410-120-1340.

f. Contractor shall pay Indian Health Care Providers for Covered Services provided to those AI/AN enrolled with the Contractor who are eligible to receive services from such providers, as follows:

(1) Participating Indian Health Care Providers are paid at a rate equal to the rate negotiated between the Contractor and the Participating Provider involved, which for a Federally Qualified Health Center (FQHC) may not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not a FQHC.

(2) Non-Participating Indian Health Care Providers that are not a FQHC must be paid at a rate that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider which is not an Indian Health Care Provider.

(3) Non-Participating Indian Health Care Providers that are a FQHC must be paid at a rate equal to the amount of payment that the Contractor would pay a FQHC that is a Participating Provider with respect to the Contractor but is not an Indian Health Care Provider for such services.

g. Contractor shall make prompt payment to Indian Health Care Providers that are Participating Providers.

h. Contractor shall pay for Emergency Services that are received from Non-Participating Providers as specified in OAR 410-141-3140.

5. Medicare Payers and Providers

a. For those Contractors affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving Fully Dual Eligibles, Contractor shall demonstrate on a yearly basis that Contractor's Provider network is adequate to provide both the Medicare and the Medicaid Covered Services to its Fully Dual Eligible population. Contractor shall identify its Providers' Medicaid participation.

b. Contractor shall assign staff to coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare.

c. Contractor is responsible for Medicare deductibles, coinsurance and Co-Payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider (who is either a Participating Provider, or a Non-Participating Provider) if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.

d. Contractor is not responsible for Medicare deductibles, coinsurance and co-payments for skilled nursing facility benefit days 21-100.

e. Contractors that are affiliated with or contracted with an entity that provides services as a Medicare Advantage plan serving Fully Dual Eligible Members for Medicare and Medicaid may not impose cost-sharing requirements on Fully Dual Eligible Members and QMB that would exceed the amounts permitted by OHP if the Member is not enrolled in the Contractor's Medicare Advantage plan.

6. Eligibility Verification for Fully Dual Eligible Clients

If Contractor is affiliated with or contracted with a Medicare Advantage plan for Fully Dual Eligibles for Medicare and Medicaid, Contractor shall verify current Member eligibility using the Automated Voice Response system or the MMIS Web Portal.

a. Pursuant to OAR 410-141-3120, Contractor shall coordinate with Medicare payers and Providers as Medically Appropriate to coordinate the care and benefits of Members who are eligible for both Medicaid and Medicare.

b. Pursuant to OAR 410-141 0420, Contractor is responsible for Medicare deductibles, coinsurance and Co-Payments up to Medicare's or Contractor's allowable for Covered Services its Medicare eligible Members receive from a Medicare Provider, who is either a Participating Provider, or a Non-Participating Provider, if authorized by Contractor or Contractor's representatives, or for Emergency Services or Urgent Care Services.

7. Encounter and Pharmacy Data

a. Contractor shall transmit claims and pharmacy data to OHA electronically using HIPAA Transaction and NCPDP Standards, respectively, and in accordance with OHA rules.

b. Contractor shall become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transmission Rules; OAR 943-120-0100 through 943-120-0200.

c. Encounter Data Submission and Processing

(1) Contractor must submit Encounter Data at least once per calendar month, on forms specified by OHA. The Encounter Data submitted must represent 50 percent of all Encounter claim types received and adjudicated by Contractor including the paid amounts regardless of whether the provider is paid on a fee-for-service or capitated basis, or whether the provider is in network (participating) or out of network (non-participating).

(2) Contractor shall submit all initial and unduplicated Encounter Data to OHA within 180 days of the date of service. Corrective action may be initiated if more than 10% of the Encounter Claims submitted are over 180 days after the date of service or if the submission of duplicate claims exceed 10% per month.

(3) OHA will pend Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information. Corrective action may be initiated if more than 10% of the Encounter Claims submitted cannot be processed because of missing or erroneous information.

(4) OHA will notify Contractor of the status of all Encounter Data processed. Notification of all pended Encounter Data shall be provided to Contractor each week that an Encounter remains pended. OHA will not necessarily notify Contractor of report errors.

(5) Contractor shall submit corrections to all pended or repended Encounters within 63 days of the date OHA sends Contractor notice that the encounters were pended. Claims for correction that are not submitted within 63 days are subject to Corrective Action.

(6) To prevent Corrective Action, Contractor may submit documentation to OHA citing specific circumstances that delay Contractor's timely submittal of adjusted or original Encounter Data. OHA will review the documentation and make a determination within 30 days on whether the circumstances cited are Acceptable. These "Acceptable" circumstances may include, but are not limited to:

(a) Member's failure to give the Provider necessary Claim information,

(b) Third-Party Resource liability coordination,

(c) Delays associated with resolving local or out-of-area Provider Claims,

(d) Member pregnancy,

(e) Third-Party submitter coordination,

(f) Hardware or software modifications to Contractor's system, and

(g) OHA recognized system issues preventing timely submission of Encounter Data.

d. Beginning with CCO capitation payments on or after July 1, 2013 and all subsequent monthly capitation payments, subject to CMS approval, OHA expects to amend this Contract to withhold one per centum (1%) of the capitation payment as an Administrative Performance Withhold (APW). Contractor will receive an APW payment for successful administrative performance, if Contractor's data submissions for the applicable historical period are found by DMAP to be complete and accurate (within error thresholds specified by OHA) for the full historical period in question.

e. Contractor shall demonstrate to OHA through proof of Encounter Data Certification and Validation that Contractor is able to attest to the accuracy, completeness and truthfulness of information required by OHA, in accordance with 42 CFR 438.604 and 438.606. Contractor shall submit the report forms listed below to OHA as described in each form or report.

Signature Authorization Form, located at:
https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx_
Encounter Data Certification and Validation Report Form, located at:
https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx
Encounter Claim Count Verification Acknowledgement and Action Form, located at:
https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx

f. Contractor shall submit Pharmacy Expense Reports as required in the following forms which are hereby incorporated by this reference:

Pharmacy Expense Reports - Report 3.1 – Pharmacy Expense Proprietary Exemption Request Form found at: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx
Pharmacy Expense Reports - Report 3.2 – Pharmacy Expense Proprietary Exemption Request Form found at: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx

8. Financial Reporting Related to Paid Claims

a. Failure by Contractor to comply with the paid claims or encounter data reporting requirements or Financial Reporting Related to Paid Claims Data, found at: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx will result in Corrective Action or such other remedies or sanctions as OHA may impose sanctions under Exhibit D, Section 31 through 35, of this Contract.

b. When Corrective Action has been initiated by OHA, Contractor may submit documentation to OHA citing specific circumstances which delay Contractor's timely submittal of the data or information described in Exhibit B, Part 8, Section 8.

c. OHA will review the documentation and make a determination within 14 calendar days on whether the circumstances cited are acceptable.

9. Third Party Liability and Personal Injury Liens

a. Contractor shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services provided during the contract year. "Third Party Liability" means any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a Member.

b. Contractor shall develop and implement written policies describing its procedures for Third Party Liability recovery. OHA may review Contractor's policies and procedures for compliance with this Contract and, to the extent OHA determines applicable, for consistency with Third Party Liability recovery requirements in 42 USC 1396a(a)(25), 42 CFR 433 Subpart D, OAR 461-195-0301 to 461-195-0350, OAR 410-141-3080 and ORS 416-510 to 416-610.

c. Contractor shall maintain records of Contractor's actions and Subcontractors' actions related to Third Party Liability recovery, and make those records available for OHA review.

d. Contractor shall report all Third Party Liability to OHA on the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report L.8 of Exhibit L.

e. Contractor shall maintain records of Third Party Liability recovery actions that do not result in recovery, including Contractor's written policy establishing the threshold for determining that it is not Cost Effective to pursue recovery action.

f. Contractor shall provide documentation about personal injury recovery actions and documentation about personal injury liens to OPAR's Personal Injury Liens Unit consistent with OAR 461-195-0301 to 461-195-0350.

g. Contractor may not refuse to provide Covered Services, and shall require that its Subcontractors may not refuse to provide Covered Services, to a Member because of a Third Party potential liability for payment for the Covered Service.

h. Contractor is the payer of last resort when there is other insurance or Medicare in effect. At OHA's discretion or at the request of the Contractor, OHA may retroactively disenroll a Member to the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(a)(A), based on OHA's determination that services may be provided Cost Effectively on a fee-for-service basis. When a Member is retroactively disenrolled under this section of this Contract, OHA will recoup all Capitation Payments to Contractor after the effective date of the Disenrollment. Contractor and its Providers may not seek to collect from a Member (or any financially responsible Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

i. Contractor shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or its Subcontractor.

j. Where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its Claim before any other entity, including Contractor or its Subcontractor, may be paid.

k. If the Third Party has reimbursed Contractor or its Subcontractor, or if a Member, after receiving payment from the Third Party Liability, has reimbursed Contractor or its Subcontractor, the Contractor or its Subcontractor must reimburse Medicare up to the full amount the Contractor or Subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.

l. Any such Medicare reimbursements described in this section are the Contractor's responsibility on presentation of appropriate request and supporting documentation from the Medicare carrier. Contractor shall document such Medicare reimbursements in its report to OHA.

m. When engaging in Third Party Liability recovery actions, Contractor shall comply with, and require its Subcontractors or agents to comply with, federal and State confidentiality requirements, described in Exhibit E of this Contract. OHA considers the disclosure of Member Claims information in connection with Contractor's TPR recovery actions a purpose that is directly connected with the administration of the Medicaid program.

10. Drug Rebate Program

Contractor shall furnish OHA with information requested by OHA regarding rebates for any covered outpatient drug provided by the Contractor, as follows:

a. Contractor acknowledges that OHA is eligible for the rebates authorized under Section 1927 of the Social Security Act (42 USC 1396r-8), as amended by section 2501 of the Patient Protection and Affordable Care Act (P.L. 111-148) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), for any covered outpatient drug provided by Contractor, unless the drug is subject to discounts under Section 340B of the Public Health Service Act.

b. Contractor shall report prescription drug data within 60 days of the date of service and as specified in Exhibit B, Part 8, Section 7 of this Contract, including the National Drug Code of each covered outpatient drug dispensed to Members.

c. Encounter Data Submissions Dispute Resolution

(1) When OHA, receives an Invoiced Rebate Dispute from a drug manufacturer, OHA will send the Invoiced Rebate Dispute to the Contractor for review and resolution. The Contractor shall assist in the resolution process as follows:

(a) Notify OHA's Encounter Data Liaison, within 15 calendar days of receipt of an Invoiced Rebate Dispute if Contractor agrees or disagrees;

(b) If the Contractor agrees with the Invoiced Rebate Dispute that an error has been made, Contractor shall correct and re-submit the Encounter Data to OHA, within 45 calendar days of receipt of the Invoiced Rebate Dispute; or

(c) If Contractor disagrees with the Invoiced Rebate Dispute that an error has been made, Contractor shall send the details of the disagreement to OHA's Encounter Data Liaison, within 45 calendar days of receipt of the Invoiced Rebate Dispute.

11. All Payers All Claims (APAC) Reporting Program

Contractor shall participate in the APAC reporting system established in ORS 442.464 and 442.466. Data submitted under this Contract may be used by OHA for purposes related to obligations under ORS 442.464 to 442.468 and OAR 409-025-0100 to OAR 409-025-0170. Submission of encounter data in accordance with this Contract will fulfill Contractor's responsibility for APAC submission. Failure of Contractor to submit under this Contract the encounter data required to fulfill the responsibility for APAC reporting is subject to compliance and enforcement under 409-025-0150 as well as under this Contract. This data will be used in conjunction with Section 5 of this exhibit.

12. Prevention/Detection of Fraud and Abuse

a. Fraud and Abuse Policies

Contractor shall have fraud and Abuse policies and procedures, and a mandatory compliance plan, in accordance with OAR 410-120-1510, 42 CFR 433.116, 42 CFR 438.214, 438.600 to 438.610, 438.808, 42 CFR 455.20, 455.104 through 455.106 and 42 CFR 1002.3, which enable the Contractor or its Subcontractor to prevent and detect fraud and Abuse activities as such

activities relate to the OHP. These policies must include compliance with all federal and State laws, operational policies and controls in areas such as Claims, prior authorization, service verification, utilization management and quality review, Member Grievance and Appeal resolution, Participating Provider credentialing and contracting, Participating Provider and staff education, and Corrective Action Plans to prevent potential fraud and Abuse activities.

Contractor shall include in the employee handbook for the Contractor or its Subcontractor, a specific discussion of the applicable fraud and Abuse Federal and State laws, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and Abuse.

b. Review of Fraud and Abuse Policies

Contractor shall review its fraud and Abuse policies annually and submit a written copy to OHA, by May 1st of every year this Contract is in effect. If the Contractor has updated the current policies, Contractor shall submit a written copy of the updated fraud and Abuse policies to OHA for approval.

c. Referral Policy

(1) Contractor shall promptly refer all suspected cases of fraud and Abuse, including fraud by its employees and Subcontractors to the Medicaid Fraud Control Unit (MFCU). Contractor may also refer cases of suspected fraud and Abuse to the MFCU or to the DHS Provider Audit Unit prior to verification.

(2) If Contractor is aware that there are credible allegations of fraud for which an investigation by MFCU is pending against a Provider, Contractor shall suspend payments to the Provider unless OHA determines there is good cause not to suspend payments or to suspend payments in part. If the act does not meet the good cause criteria, the Contractor shall work with the MFCU to determine if any Participating Provider contract should be terminated.

(3) Fraud and Abuse Referral Characteristics of a Case that should be referred.

(a) Examples of fraud and Abuse within Contractor's network:

(i) Providers who consistently demonstrate a pattern of intentionally reporting encounters or services that did not occur. A pattern would be evident in any case where 20% or more of sampled or audited services are not supported by documentation in the Clinical Records. This would include any suspected case where it appears that the Provider knowingly or intentionally did not deliver the service or goods billed;

(ii) Providers who consistently demonstrate a pattern of intentionally reporting overstated or up coded levels of service. A pattern would be evident by 20% or more of sampled or audited services that are billed at a higher-level procedure code than is documented in the Clinical Records;

(iii) Any suspected case where the Provider intentionally or recklessly billed Contractor more than the usual charge to non-Medicaid recipients or other insurance programs;

(iv) Any suspected case where the Provider purposefully altered, falsified, or destroyed Clinical Record documentation for the purpose of artificially inflating or obscuring his or her compliance rating or collecting Medicaid payments otherwise not due. This includes any deliberate misrepresentation or omission of fact that is material to the determination of benefits payable or services which are covered or should be rendered, including dates of service, charges or reimbursements from other sources, or the identity of the patient or Provider;

(v) Providers who intentionally or recklessly make false statements about the credentials of persons rendering care to Members;

(vi) Primary Care Physicians who intentionally misrepresent medical information to justify referrals to other networks or out-of-network Providers when they are obligated to provide the care themselves;

(vii) Providers who intentionally fail to render Medically Appropriate Covered Services that they are obligated to provide to Members under their Subcontracts with the Contractor and under OHP regulations;

(viii) Providers who knowingly charge Members for services that are Covered Services or intentionally balance-bill a Member the difference between the total fee-for-service charge and Contractor's payment to the Provider, in violation of OHA rules;

(ix) Any suspected case where the Provider intentionally submitted a Claim for payment that already has been paid by OHA or Contractor, or upon which payment has been made by another source without the amount paid by the other source clearly entered on the Claim form, and receipt of payment is known to the Provider; and

(x) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.

(b) Examples of fraud and Abuse in the administration of the OHP program:

(i) Evidence of corruption in the Enrollment and Disenrollment process, including efforts of State employees or Contractors to skew the risk of unhealthy patients toward or away from one of the Contractors; and

(ii) Attempts by any individual, including employees and elected officials of the State, to solicit kickbacks or bribes, such as a bribe or kickback in connection with placing a Member into a carved out program, or for performing any service that the agent or employee is required to provide under the terms of his employment.

(c) Examples of patient Abuse and neglect:

(i) Any Provider who hits, slaps, kicks, or otherwise physically abuses any patient;

(ii) Providers who sexually abuse any patient;

(iii) Any Provider who intentionally fails to render Medically Appropriate care, as defined in this Contract, by the OHP Administrative Rules and the standard of care within the community in which the Provider practices. If the Provider fails to render Medically Appropriate care in compliance with the Member's decision to exercise his or her right to refuse Medically Appropriate care, or because the Member exercises his rights under Oregon's Death with Dignity Act or pursuant to Advance Directives, such failure to treat the Member shall not be considered patient abuse or neglect; and

(iv) Providers, e.g. residential counselors for developmentally disabled or personal care Providers, who deliberately neglect their obligation to provide care or supervision of vulnerable persons who are Members (children, the elderly or developmentally disabled individuals).

d. When to Report Fraud and Abuse

(1) Contractor shall report to the MFCU an incident with any of the referral characteristics listed in Subsection c, of this section. Contractor shall report any other incident found to have characteristics which indicate fraud or Abuse which Contractor has verified.

(2) Contractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. Contractor shall ensure that all Subcontractors comply with this provision.

(3) Contractor must report the following to the Authority:

(a) Number of complaints of fraud and abuse made to the OHA or the Medicaid Fraud Unit that warrant preliminary investigation

(b) For each matter that warrants investigation, supply the following:

(i) Name, and Member ID number

(ii) Source of complaint

(iii) Type of provider

(iv) Nature of complaint

(v) Approximate dollars involved

(vi) Legal and administrative disposition of the case

e. How to Refer a Case of Provider Fraud or Abuse

The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (971) 673-1880, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (971)-673-1890. The DHS Provider Audit Unit phone number is (503) 378-3500, address 2850 Broadway St. NE, Salem, Oregon 97303, and fax is (503) 378-3437.

f. Obligations to Assist the MFCU and OHA

(1) Contractor shall permit the MFCU or OHA or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Contractor or by or on behalf of any Subcontractor, as required to investigate an incident of fraud and Abuse.

(2) Contractor shall cooperate, and requires its Subcontractors to cooperate, with the MFCU and OHA investigator during any investigation of fraud or Abuse.

(3) In the event that Contractor reports suspected fraud, or learns of an MFCU or OHA investigation, Contractor should not notify or otherwise advise its Subcontractors of the investigation. Doing so may compromise the investigation.

(4) Contractor shall provide copies of reports or other documentation, including those requested from the Subcontractors regarding the suspected fraud at no cost to MFCU or OHA during an investigation.

g. Prevention and Detection of Member Fraud and Abuse

Contractor, if made aware of suspected fraud or Abuse by a Member (e.g. a Provider reporting Member fraud and Abuse), shall report the incident to the DHS Fraud Unit. Address suspected Member fraud and Abuse reports to DHS Fraud Investigation P.O. Box 14150 Salem, Oregon 97309-5027, phone number 1-888-FRAUD01 (888-372-8301), facsimile number 503-373-1525 ATTN: HOTLINE.

13. Abuse Reporting and Protective Services

Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765.

14. Disclosure of Ownership Interest

a. Contractor shall provide OHA with full and complete information of each person or corporation with an ownership or control interest (which equals or exceeds 5 percent) in the Coordinated Care Organization, or any Subcontractor in which Contractor has an ownership interest that equals or exceeds 5 percent, consistent with 42 CFR 455.100 through 42 CFR 455.106, and include the following:

(1) Whether any of the persons named in Section 2 are related to one another as a spouse, parent, child or sibling.

(2) Name any other disclosing entity in which a person named in section 2 also has an ownership or controlling interest.

(3) Any person with an ownership or control interest in a Subcontractor with whom the provider has had business transactions totaling more than $25,000 during a 12 month period ending on the date or request; and any significant business transactions between provider and wholly-owned supplier or between provider and Subcontractor during a 5 year period ending on the date of request.

(4) Any person who has an ownership or controlling interest in the provider, or is an agent or managing employee of the provider, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or other federal services program since inception of those programs.

15. Changes in Ownership

Change in ownership is consolidation or merger of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, with or into a corporation or entity or person, or any other reorganization or transaction or series of related transactions involving the transfer of more than 50% of the equity interest in Contractor or more than 50% of the equity interest in a corporation or other entity or person controlling or controlled by Contractor, or the sale, conveyance or disposition of all or substantially all of the assets of Contractor, or of a corporation or other entity or person controlling or controlled by Contractor, in a transaction or series of related transactions.

a. Contractor shall notify OHA at least 90 calendar days prior to any change in ownership and reimburse OHA for all legal fees reasonably incurred by OHA in reviewing the proposed assignment or transfer and in negotiating and drafting appropriate documents.

b. Contractor shall notify OHA of any changes of address, and as applicable licensure status as a health plan with DCBS or as a Medicare Advantage plan, or Federal Tax Identification Number (TIN), within 14 calendar days of the change.

c. Failure to notify OHA of any of the above changes may result in the imposition of a sanction from OHA and may require Corrective Action to correct payment records, as well as any other action required to correctly identify payments to the appropriate TIN.

d. Contractor understands and agrees that Contractor is the legal entity obligated under this Contract and that OHA is engaging the expertise, experience, judgment, representations and warranties, and certifications of the Contractor set forth in this Contract and in the Application for this Contract. Contractor may not transfer, Subcontract, reassign or sell its contractual or ownership interests, such that Contractor is no longer available to provide OHA with its expertise, experience, judgment and representations and certifications, without first obtaining OHA's prior written approval 120 days before such transfer, subcontract, reassignment or sale occurs, except as otherwise provided in Exhibit B, Part 4, Section 2 of this Contract governing adjustments in Service Area or Enrollment, Exhibit D, Section 18 "Subcontracting".

e. As a condition precedent to obtaining OHA's approval, Contractor shall provide to OHA all of the following:

(1) The name(s) and address(es) of all directors, officers, partners, owners, or persons or entities with beneficial ownership interest of more than 5% of the proposed new Entity's equity; and

(2) Representation and warranty signed and dated by the proposed new Entity and by Contractor that represents and warrants that the policies, procedures and processes issued by the current Contractor will be those policies, procedures, or processes provided to OHA by the current Contractor or by an existing Contractor within the past two years, and that those policies, procedures and processes still accurately describe those used at the time of the ownership change and will continue to be used once OHA has approved the ownership change request, except as modified by ongoing Contract and Administrative Rule requirements. If Contractor and the proposed new Entity cannot provide representations and warranties required under this subsection, OHA shall be provided with the new policies, procedures and processes proposed by the proposed new Entity for review consistent with the requirements of this Contract; and

(3) The financial responsibility and solvency information for the proposed new Entity for OHA review consistent with the requirements of this Contract; and

(4) Contractor's assignment and assumption agreement or such other form of agreement, assigning, transferring, subcontracting or selling its rights and responsibilities under this Contract to the proposed new Entity, including responsibility for all records and reporting, provision of services to Members, payment of valid claims incurred for dates of services in which Contractor has received a Capitation Payment, and such other tasks associated with termination of Contractor's contractual obligations under this Contract.

f. OHA may require Contractor to provide such additional information or take such actions as may reasonably be required to assure full compliance with Contract terms as a condition precedent to OHA's agreement to accept the assignment and assumption or other agreement.

g. OHA will review the information to determine that the proposed new entity may be certified to perform all of the obligations under this Contract and that the new entity meets the financial solvency requirements and insurance requirements to assume this Contract.

16. Credentialing

a. Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information and recredentialing of Participating Providers, programs and facilities used to deliver Covered Services, consistent with PPACA Section 6402, 42 CFR 438.214, 42 CFR 455.400-455.470, OAR 410-141-3120 and Exhibit G, except as provided in Subsection b, of this Section. These procedures shall also include collecting proof of professional liability insurance.

b. If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Contractor shall document, certify and report on Exhibit G the date that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

(1) If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then:

(a) Participating Providers must meet the definitions for QMHA (qualified mental health associate) or QMHP (qualified mental health professional) as described in Exhibit A, Definitions and provide services under the supervision of a LMP (licensed medical practitioner) as defined in Exhibit A, Definitions; or

(b) For Participating Providers not meeting either the QMHP or QMHA definition, Contractor shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

(2) If programs or facilities are not required to be licensed or certified by a State of Oregon board or licensing agency, then the Contractor shall obtain documentation from the program or facility that demonstrates accreditation by nationally recognized organizations recognized by the OHA for the services provided (e.g., Council on Accredited Rehabilitation Facilities (CARF), or The Joint Commission (TJC) where such accreditation is required by OHA rule to provide the specific service or program.

c. Contractor shall not discriminate with respect to participation, reimbursement or indemnification as to any Provider who is acting within the scope of the Provider's license or certification as specified in 42 CFR 438.12 and under OAR 410-141-3120 on the basis of such license or certification. If Contractor declines to include individual or groups of providers in its network, it must give written notice of the reason for its decision. This paragraph does not:

(1) Prohibit Contractor from including Providers only to the extent necessary to meet the needs of Members,

(2) Require that Contractor contract with any health care provider willing to abide by the terms and conditions for participation established by the Contractor,

(3) Preclude Contractor from establishing varying reimbursement rates based on quality or performance measures consistent with Contractor's responsibilities under this Contract, or

(4) Preclude Contractor from using different reimbursement amounts for different specialties or for different Practitioners in the same specialty.

d. Contractor 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 must provide accurate and timely information about license or certification expiration and renewal dates to the OHA. Contractor may not refer Members to or use providers who do not have a valid license or certification required by state or federal law. If Contractor 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 Contractor must immediately notify OHA's Provider Services Unit.

e. To support the OHA objective of providing efficient and quality health care to Members, Contractor shall utilize a universal credentialing process for the centralized collection, verification and distribution of all Provider data to be used for credentialing and privileging.

f. Contractor may not refer Members to or use providers who have been terminated from OHA or excluded as Medicare, CHIP or Medicaid providers by 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 and 42 CFR 455.3,b.. Contractor may not accept billings for services to Members provided after the date of the provider's exclusion, conviction, or termination. If Contractor 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 Contractor must immediately notify OHA's Provider Services Unit.

g. Only registered National Provider Identifiers (NPIs) and taxonomy codes reported to the OHA in the Provider Capacity Report may be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider.

h. Contractor shall require each Physician and other qualified provider to have a unique provider identification number that complies with 42 USC 1320d-2(b).

h. Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the delivery of covered Coordinated Care Services, applicable administrative rules, and the Contractor's administrative policies.

17. Subrogation

Contractor agrees, and shall require its Subcontractors to agree, to subrogate to OHA any and all claims the Contractor or Subcontractor has or may have against manufacturers, wholesale or retail suppliers, sales representatives, testing laboratories, or other providers in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other products. Nothing in this provision prevents Oregon from working with the CCO and releasing its right to subrogation in a particular case.

Exhibit B –Statement of Work - Part 9 – Quality Performance Outcomes and Accountability

1. Quality Assurance and Performance Improvement Program Requirements

Contractor shall develop and operate a Quality Assurance and Performance Improvement Program for the services it furnishes to its OHP Members in accordance with 42 CFR 438.240 under an annual quality strategy and work plan with feedback loops and reported annually, to OHA. Contractor shall implement quality assurance and performance improvement measures demonstrating the methods and means by which Contractor carries out planned or established mechanisms for:

a. Establishing a complaint, Grievance and Appeals resolution process, including how that process is communicated to Members and providers;

b. Establishing and supporting an internal Quality Improvement committee that develops and operates under the annual quality strategy and work plan with feedback loops; and

c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies. Contractor shall have in effect mechanisms to detect both underutilization and over utilization of services.

d. Having mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.

e. Conducting its own evaluation of the impact and effectiveness of its annual quality strategy and work plan and report annually, to OHA.

Contractor shall participate as a member of the OHA Quality and Performance Improvement Work Group (QPIWG).

2. Quality and Performance Outcomes

As required by Health System Transformation, Contractor shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into this Contract.

Contractor shall implement the data reporting systems necessary to timely submit claims data to the All Payer All Claims data system in accordance with ORS 414.625, and the requirements of ORS 442.464 to 442.466.

Annually, Contractor must:

a. Measure and report to OHA its performance, using standard measures required by OHA; and

b. Submit data specified by OHA, that enables OHA to measure the Contractor's performance;

3. Measurement and reporting requirements

Contractor shall plan for and implement the necessary organizational infrastructure to address performance standards established for this Contract, as follow:

a. In the first year, accountability is for reporting purposes only.

b. In future years, Contractor shall be accountable for meeting OHA's specified performance benchmarks, specifically: to meet or exceed minimum performance expectations set for core measures and to improve on past year performance for transformational measures (see below for description of care and transformational categories).

c. Initially, "reporting year" shall be the period of time starting on the effective date of this Contract and ending December 31, 2013.

d. Performance relative to targets affects Contractor's eligibility for financial and non-financial rewards. Contractor's performance with respect to minimum expectations will be assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight will be aimed at root cause analysis and assisting Contactor in developing improvement strategies; continued subpar performance will lead to progressive remediation established in this Contract, including increased frequency of monitoring, Corrective Action Plans, Enrollment restrictions, financial and non-financial sanctions, and ultimately, non-renewal of this Contract.

e. OHA will convene a Metrics and Scoring Committee to assist in building measure specifications and establishing performance targets for Year 2 forward. The Committee will also advise OHA annually on adopting, retiring, or re-categorizing Contractor's performance measures, based on evaluation of the metrics' appropriateness and effectiveness.

f. Annual reporting serves as the basis for holding Contractor accountable to contractual expectations; however, OHA will assess Health Systems Transformation performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The Parties shall document any changes agreed to during these informal procedures.

g. The performance measures reporting requirements will measure the quality of health care and services during a time period in which Contractor was providing Coordinated Care Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of this Contract, even if Contract expiration, termination or amendment results in a termination, modification or reduction of this Contract or the Enrollment or Service Area.

h. Contractor shall include any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

Contractor shall be accountable for both core and transformational measures of quality and outcomes:

a. Core measures are Triple-Aim oriented and gauge Contractor performance against key expectations for care integration and coordination, consumer satisfaction, quality and outcomes. The measures are uniform across CCOs and address the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).

b. Transformational metrics will assess Contractor progress toward the broad goals of Health System Transformation and therefore require systems transitions and the development of best practices regarding transformational requirements such as patient-centered care and the reduction of health disparities. This subset may include newer kinds of indicators (for which Contractor may have less measurement experience) or indicators that entail collaboration with other care partners.

c. Accountability metrics that are applicable in Year 1 of this Contract are found at http://www.oregon.gov/OHA/OHPB/health-reform/docs/cco-rfa-attachment-8-table-c1.pdf

5. Performance Improvement Projects

a. Contractor shall have an ongoing program of performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction. At least one performance improvement project shall seek improvement in an area of poor performance in the care coordination for adults with serious and persistent mental illness. The ongoing program of PIPs shall include the following:

(1) Measurement of performance using objective quality indicators;

(2) Implementation of system interventions to achieve improvement;

(3) Evaluation of the effectiveness of the interventions; and

(4) Planning and initiation of activities for increasing or sustaining improvement.

b. Each PIP must be completed in a reasonable time period as to generally allow information on the success of PIP(s) in the aggregate to produce new information on quality every year.

c. Contractor must report the status and results of each project to OHA as requested.

6. Program Requirements

Contractor shall report to OHA Health Promotion and Disease Prevention Activities its national accreditation organization results and HEDIS measures as required by the Department of Consumer and Business Services (DCBS) in OAR 836-053-1000. A copy of the reports may be provided to the OHA Performance Improvement Coordinator concurrent with any submission to DCBS

7. External Quality Review

a. In conformance with 42 CFR 438 Subpart E, Contractor shall cooperate and shall require its subcontractors and Providers to cooperate with the Authority by providing access to records and facilities for the purpose of an annual external, independent professional review of the quality outcomes and timeliness of, and access to, Services provided under this Contract.

b. If an External Quality Review Organization (EQRO) identifies an adverse clinical situation in which follow-up is needed to determine whether appropriate care was provided, the EQRO will report the findings to OHA and Contractor.

(1) Contractor shall provide, based on the EQRO report:

(a) An annual PIP validation;

(b) An annual performance measurement validation;

(c) An information system capabilities assessment conducted every two years; and

(d) A compliance review conducted within the previous 3-year period to determine Contractor's compliance with standards established by OHA to determine if Contractor shall develop and comply with a Corrective Action Plan as reviewed and approved by OHA.

Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all the Work to be performed under this Contract, OHA will pay Contractor a monthly CCO Payment for each Member enrolled under the Contract according to OHA records. The monthly CCO Payment rate authorized for each Member is that amount indicated in this Exhibit, Attachment 2, CCO Rates, for each Member's Rate Group as "Total Services with Admin." OHA will prorate the CCO Payment for Members who are enrolled mid-month. OHA may withhold payment for new Members when, and for so long as, OHA determines that Contractor meets the circumstances cited in 42 CFR 434.67.

b. The general description of the basis for calculating CCO Payments is described in Exhibit C, Attachment 1, Calculation of CCO Payment Rates.

The Covered Services described in Exhibit B, Part 1, Section 2 have been divided into categories of services. Categories of service in this section describe but do not replace or supercede the scope of Covered Services described in Exhibit B, Part 1 through Part 6; categories of services are used to develop CCO Payment rates as described in Exhibit C, Attachment 2.

(1) Mandatory Categories of Services.

(a) For purposes of developing CCO Rates, the following service categories constitute the mandatory categories of Covered Services for Members eligible for the OHP Plus Benefit Package:

Substance Use Disorder Services, Outpatient Treatment Services, Methadone/LAAM dosing and dispensing;
Diagnostic Services/Lab/X-Ray;
DME/Medical Supplies/Hearing Aids & Supplies;
Exceptional Needs Care Coordination;
Home Health/Private Duty Nursing/Hospice;
Inpatient Hospital - Basic includes Acute Detoxification;
Inpatient Hospital – Hysterectomy;
Inpatient Hospital - Family Planning;
Inpatient Hospital – Maternity;
Inpatient Hospital – Newborn;
Inpatient Hospital – Sterilization;
Mental Health-Acute Inpatient - Inpatient Psychiatric Treatment;
Mental Health-Outpatient Other - Outpatient hospital based;
Mental Health- Alternative to Inpatient - Inpatient sub-acute (like residential);
Mental Health- Assessment/Evaluation - Initial Mental Health assessment or screening;
Mental Health- Case Management - Outpatient Case Management by MH providers of MH clients;
Mental Health- Consultation - Mental Health providers offering additional evaluation beyond assessment/screening;
Mental Health- Interpretation Services - Such as supportive employment, ACT, Etc. special MH programs including WRAP services;
Mental Health-Intensive Treatment Services - Mostly kids residential;

Mental Health- Medical Management - Mental Health MD/NP overseeing Medicine of MH client;
Mental Health-Optional Therapy - Most all remaining MH services done out in the Community setting;
Mental Health- Physician Inpatient - Inpatient professional component while the client is in the hospital;
Mental Health- Physician Outpatient - Outpatient Mental Health MD services in either hospital or community setting;
Mental Health- Support Day Treatment - Day treatment services in Community settings;
Outpatient Hospital/ASC - Basic includes Emergency Room;
Outpatient Hospital/ASC - Family Planning;
Outpatient Hospital/ASC – Maternity;
Outpatient Hospital/ASC – Sterilization;
Outpatient Hospital/ASC – Hysterectomy;
Physician- Basic includes Somatic Mental Health and Vaccines for Children;
Physician - Family Planning;
Physician – Hysterectomy;
Physician – Maternity;
Physician – Newborn;
Physician - Other includes Dialysis, Hearing Services PT/OT Services, Speech/Language Pathology, etc.;
Post Hospital Extended Care;
Prescription Drugs – Basic;
Prescription Drugs - Family Planning;
Tobacco Cessation;
Transportation – Ambulance; and
Vision Exams, Therapy, Materials

(b) For purposes of developing CCO Rates, the following service categories constitute the categories of Covered Services for Members eligible for the OHP Standard Benefit Package:

Substance Use Disorder Services, Outpatient Treatment Services, Methadone/LAAM dosing and dispensing;
Diagnostic Services/Lab/X-Ray;
DME (limited, on-going, not a one-time basis);
Exceptional Needs Care Coordination;
Home Health/Private Duty Nursing/Hospice;
Inpatient Hospital - Basic includes Acute Detoxification;
Inpatient Hospital – Hysterectomy;
Inpatient Hospital - Family Planning;
Inpatient Hospital – Maternity;
Inpatient Hospital – Sterilization;
Mental Health-Acute Inpatient - Inpatient Psychiatric Treatment;
Mental Health-Outpatient Other - Outpatient hospital based;
Mental Health- Alternative to Inpatient - Inpatient sub-acute (like residential);
Mental Health- Assessment/Evaluation - Initial Mental Health assessment or screening;
Mental Health- Case Management - Outpatient Case Management by MH providers of MH clients;

Mental Health- Consultation - Mental Health providers offering additional evaluation beyond assessment/screening;
Mental Health- Interpretation Services - Such as supportive employment, ACT, Etc. special MH programs including WRAP services;
Mental Health-Intensive Treatment Services - Mostly kids residential;
Mental Health- Medical Management - Mental Health MD/NP overseeing Medicine of MH client;
Mental Health-Optional Therapy - Most all remaining MH services done out in the Community setting;
Mental Health- Physician Inpatient - Inpatient professional component while the client is in the hospital ;
Mental Health- Physician Outpatient - Outpatient Mental Health MD services in either hospital or community setting;
Mental Health- Support Day Treatment - Day treatment services in Community settings;
Outpatient Hospital/ASC - Basic includes Emergency Room;
Outpatient Hospital/ASC - Family Planning;
Outpatient Hospital/ ASC – Maternity;
Outpatient Hospital/ASC – Sterilization;
Outpatient Hospital/ASC – Hysterectomy;
Physician- Basic includes Somatic Mental Health and Vaccines for Children;
Physician - Family Planning;
Physician – Hysterectomy;
Physician - Other includes Dialysis, Hearing Services PT/OT Services, Speech/Language Pathology, etc.;
Post Hospital Extended Care;
Prescription Drugs;
Tobacco Cessation; and
Transportation – Ambulance.

The OHP Standard Benefit Package may exclude or limit some benefits in the above listed service categories as described in the following rules:

(i) OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(ii) OAR 410-122-0055, Standard Benefit Package Limitations;

(iii) OAR 410-125-0080, Inpatient Services;

(iv) OAR 410-127-0055, Co-Pay for OHP Standard Benefit Package;

(v) OAR 410-129-0195, Hearing/Speech for Standard Benefit Package;

(vi) OAR 410-130-0163, Medical Supplies for Equipment for Standard Benefit Package;

(vii) OAR 410-131-0275, Physical Occupational Therapy for Standard Benefit Package;

(viii) OAR 410-132-0055, Private Duty Nurse for OHP Standard Benefit Package;

(ix) OAR 410-140-0115, Co-Pay for Standard Benefit Package;

(x) OAR 410-141-0480, Oregon Health Plan Benefit Package of Covered Services; and

(xi) OAR 410-148-0090, Non-Covered Services for Standard Benefit Package.

For specific details on OHA's end of the month deadline and Enrollment dates schedule contact the DMAP CCO Coordinator.

c. If Contractor has a contractual relationship with a designated Type A, Type B, or Rural critical access hospital, the Contractor and each said hospital shall provide representations and warranties to OHA:

(1) That said contract establishes the total reimbursement for the services provided to persons whose medical assistance benefits are administered by the Contractor; and

(2) That hospital reimbursed under the terms of said contract is not entitled to any additional reimbursement from OHA for services provided to persons whose medical assistance benefits are administered by Contractor.

d. In addition to the base CCO Payment rate paid to Contractor, OHA will pay a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in Attachment 2 of this Exhibit C. Contractor shall distribute such hospital reimbursement adjustment amount to eligible hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups, in accordance with requirements established by OHA.

e. Until July 1, 2014, Contractor that contracts with a Type A or Type B hospital or a rural critical access hospital shall reimburse the hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the global budget. This section does not prohibit Contractor and a hospital from mutually agreeing to reimbursement arrangements.

f. For Members with chronic conditions (as defined in Oregon's Medicaid state Plan Amendment 2703 and as specified in OAR 410-141-0860), OHA will pay Contractor a PCPCH case rate payment, outside of the Capitation Payment.

The tiered payment, per Member assigned to PCPCH per month with chronic conditions is as follows: $10 for tier 1, $15 for tier 2 and $24 for tier 3.

2. Payment in Full

The consideration listed in Attachment 2 to this Exhibit C is the total consideration payable to Contractor for all work performed under this Contract.

3. Changes in Payment Rates

The CCO Payment rate established in Attachment 2, to this Exhibit may be changed only by amendment to this Contract pursuant to Exhibit D, Section 20 of this Contract.

a. Changes in the CCO Payment rate as a result of adjustments to the Service Area and/or to the Enrollment limit may be required pursuant to Exhibit B, Part 4, Section 2 of this Contract.

b. The CCO Payments authorized to be paid under this Contract are based on the funded condition-treatment pairs on the Prioritized List of Health Services contained in OAR 410-141-2520 in effect on the date this Contract is executed, subject to the terms of this Contract.

(1) Pursuant to ORS 414.720, the Prioritized List of condition-treatment pairs developed by the HERS may be expanded, limited or otherwise changed. Pursuant to ORS 414.715 and 414.735, the funding line for the services on the Prioritized List may be changed by the Legislature.

(2) In the event that insufficient resources are available during this Contract period, ORS 414.735 provides that reimbursement shall be adjusted by eliminating services in the order of priority recommended by the HERS, starting with the least important and progressing toward the most important.

(3) Before instituting reductions in Covered Services pursuant to ORS 414.735, OHA is required to obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session.

(4) In addition, OHA will notify Contractor at least two weeks prior to any legislative consideration of such reductions.

(5) Adjustments made to the Covered Services pursuant to ORS 414.735 during this Contract year will be referred to the actuary who is under contract with OHA for the determination of capitation rates. The actuary will determine any rate modifications required as the result of cumulative adjustments to the funded list of Covered Services based on the totality of the OHP rates for all Contractors (total OHP rates).

(a) For changes made during the first year of the two year per capita cost period since the list was last approved by the Legislative Assembly or the Emergency Board, the actuary will consider whether changes are covered by the trend rate included in the existing total OHP capitation rate(s) and, thus, not subject to adjustment or are services moved from a non-covered service to a Covered Service.

(b) If the net result under Paragraph (5) or (5) (a) above for services subject to the adjustment is less than 1% of the total OHP rates, no adjustment to the CCO Payment rate(s) in Attachment 2, to this Exhibit will be made.

(c) If the net result under Paragraph (5) or (5) (a) above is 1% or greater of the total OHP rates, the CCO Payment rate(s) in Attachment 2, to this Exhibit will be amended pursuant to Exhibit D, Section 20 of this Contract.

(d) The assumptions and methodologies used by the actuary to determine whether the net result is more or less than 1% shall be made available to Contractor.

(6) Notwithstanding the foregoing, Subsections b (1) through (5) do not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

4. Timing of CCO Payments

a. The date on which OHA will process CCO Payments for Contractor's Members depends on whether the Enrollment occurred during a weekly or monthly Enrollment cycle. OHA will provide a schedule of Enrollment end of month deadlines for each month of the Contract period. On months where the first of the month falls on a Friday, Saturday or Sunday, CCO Payments will be made available to the Contractor no later than the 11th day of the month to which such payments are applicable.

(1) Weekly Enrollment: For Clients enrolled with Contractor during a weekly Enrollment cycle, CCO Payments will be made available to Contractor no later than two weeks following the date of Enrollment, except for those occurrences each year when the weekly and monthly Enrollment start date are the same day.

(2) Monthly Enrollment: For Clients enrolled with Contractor during a monthly Enrollment cycle, CCO Payments shall be made available to Contractor by the 10th day of the month to which such payments are applicable, except for those occurrences each year when the weekly and monthly CCO Payments coincide with each other.

b. Both sets of payments described in Subsection a, of this section shall appear on the monthly CCO Payment/Remittance Advice. To assist Contractor with Enrollment and CCO Payment/Remittance Advice reconciliation, OHA will include in the Enrollment transaction the original adjustment amount and the paid amount for each of Contractor's Members. The inclusion of this information does not ensure or suggest that the two transaction files will balance. If Contractor believes that there are any errors in the Enrollment information, Contractor shall notify OHA. Contractor may request an adjustment to the Remittance Advice no later than 18 months from the affected Enrollment period.

c. OHA will make retroactive CCO Payments to Contractor for any Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to Contractor once OHA manually processes the correction(s).

d. OHA will make retroactive Capitation Premium/Payments to Contractor for newborn Members. Such payments will be made to Contractor by the 10th day of the month after OHA adds the newborn(s).

e. Services that are not Coordinated Care Services provided to a Member or for any health care services provided to Clients are not entitled to be paid as Capitated Premium/Payments. Fee-for-service Claims for payment must be billed directly to OHA by Contractor, its Subcontractors, or its Participating Providers, all of which must be enrolled with OHA in order to receive payment. Billing and payment of all fee-for-service Claims shall be pursuant to and under OAR Chapter 410, Division 120.

5. Settlement of Accounts

a. If a Member is disenrolled, any CCO Payments received by Contractor after the effective date of Disenrollment will be considered an overpayment and will be recouped by OHA from future CCO Payments.

b. OHA will have no obligation to make any payments to Contractor for any period(s) during which Contractor fails to carry out any of the terms of this Contract.

c. If Contractor requests, or is required by OHA, to adjust the Service Area or Enrollment limit or to transfer or reassign Members due to loss of Provider capacity or for other reasons, any delay in executing amendments or completing other Contract obligations pursuant to Exhibit B, Part 4, Section 2, Adjustments in Service Area or Enrollment, may result in recovery of CCO Payments to which Contractor was not entitled under the terms of this Contract.

d. Any payments received by Contractor from OHA under this Contract, and any other payments received by Contractor from OHA, or any other source to which Contractor is not entitled under the terms of this Contract shall be considered an overpayment and shall be recovered from Contractor.

e. Sanctions imposed that result in Recovery Amounts pursuant to Exhibit D, Section 32 through 35 of this Contract are subject to recovery and shall be recovered from Contractor.

f. Any overpayment or Recovery Amount under Exhibit B of this Contract may be recovered by recoupment from any future payments to which Contractor would be entitled from OHA, or pursuant to the terms of a written agreement with OHA, or by civil action to recover the amount. OHA may withhold payments to Contractor for amounts disputed in good faith and shall not be charged interest on any payments so withheld.

g. OHA will recover from Contractor payments made to Contractor or to other Providers for sterilizations and hysterectomies performed where the Contractor failed to meet the requirements of Exhibit B, Part 1, Section 6, of this Contract, the amount of which will be calculated as follows:

(1) Contractor shall, within 60 days of a request from OHA, provide OHA with a list of all Members who received sterilizations or hysterectomies, from Contractor or its Subcontractors during the Contract year and copies of the informed consent form or certification. OHA will be permitted to review the Medical Records of these individuals selected by OHA for purposes of determining whether Contractor complied with OAR 410-130-0580.

(2) By review of the informed consent forms, certifications, and other relevant Medical Records of Members, OHA will determine for the Contract year the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of Exhibit B, Part 1, Section 6, of this Contract.

(3) Sterilizations and hysterectomies that Contractor denies for payment shall not be included in the recoupment calculation, however, they must be reported in the submission. The report of these sterilizations and hysterectomies must be accompanied by a signed

statement certifying that Contractor did not make payment for the surgery or any services, which are specifically related to the procedure.

(4) The number of vasectomy, tubal ligation, and hysterectomy procedures that do not meet the documentation requirements of Exhibit B, Part 1, Section 6, of this Contract, shall be multiplied by the assigned "value of service".

(5) "Value of service" for vasectomy, tubal ligation, and hysterectomy means the OHP amount calculated by OHA's internal actuarial unit for each category of service using the encounter data.

(6) The results of Paragraph (4) of this subsection will be totaled to determine Contractor's overpayment for hysterectomies and sterilizations subject to recovery pursuant to Exhibit C, Section 4, Subsection f, of this Contract.

(7) The final results of the review will be conveyed to Contractor in a timely manner within 90 days of determination.

h. The requirements of this section expressly survive the termination of this Contract, and shall not be affected by any amendment to this Contract, even if amendment results in modification or reduction of Contractor's Service Area or Enrollment. Termination, modification, or reduction of Service Area does not relieve Contractor of its obligation to submit sterilization/hysterectomy documentation for dates of service applicable to Service Areas while they were paid a CCO Payment under this Contract, nor does it relieve Contractor of the obligation to repay overpayment amounts or Recovery Amounts under this section.

i. Notwithstanding anything set forth elsewhere in this Exhibit C, Contractor shall be paid the supplemental payments described in Exhibit B, Part 4, Section 9, for distribution to participating Patient Centered Primary Care Home clinics and, if applicable to Contractor, the supplemental payments described in Exhibit B, Part 4, Section 8, for distribution to participating Health Leadership Council High Value Medical Homes. Such supplemental payments shall be considered Payments within the meaning of this Contract.

Global Payment Rate Methodology

OHA has developed actuarially set Adjusted Per Capita Costs (Capitation Rates) to reimburse plans for providing the Covered Services. A full description of the methodology used to calculate per capita costs may be found in the OHA document *"Capitation Rate Development Coordinated Care Organizations in the Second Wave August 2012 – December 2013*, dated July 13, 2012, which is by this reference incorporated herein.

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County

	Base Case Rate	Base Hospital Reimbursement Allowance	Admin Allowance	Hospital Administrative Allowance	Case Rate
Maternity Case Rate:					
Case Rate w/o Admin	$ 8,655.74	$ 2,069.03	$ 940.77	$ 744.61	**$ 12,410.14**
Admin %					7.58%
% (Admin + Hospital Administrative Allowance)					13.58%
Total HRA (Base HRA Adjustment + Hospital Administrative Allowance)					$ 2,813.63

	Base Case Rate	Admin Allowance	Case Rate
Bariatric Case Rate:			
Medicaid Only	$ 15,874.57	$1,554.69	**$ 17,429.26**
Admin %			8.92%
Dual Eligibles	$1,633.27	$159.96	**$ 1,793.23**
Admin %			8.92%

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **Temporary Assistance to Needy Families - Adults**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$71.12	$0.00	$71.12
	Primary Care Physician	*$19.23*		
	Non-Primary Care Physician	*$51.89*		
Outpatient		$64.34	$29.12	$93.45
	DRG Outpatient	*$61.88*		
	A & B Outpatient	*$2.46*		
	Other Outpatient	*$0.00*		
Inpatient		$38.48	$17.60	$56.08
	DRG Inpatient	*$37.40*		
	A & B Inpatient	*$1.09*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$34.53	$0.00	$34.53
Chemical Dependency		$11.19	$0.00	$11.19
Primary Care Patient Centered Home		$10.63	$0.00	$10.63
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$8.98	$0.00	$8.98
Mental Health Services		$20.67	$1.65	$22.32
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$259.92	$48.37	$308.29

	Unadjusted	**$259.92**
	Base HRA Adjustment	**$48.37**
	Hospital Administrative Allowance	**$20.45**
	Admin	**$28.77**
Total Services with Admin		**$357.50**
	Admin %	8.05%
% (Admin + Hospital Administrative Allowance)		13.77%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $68.81

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **Poverty Level Medical - Adults**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$129.63	$0.00	$129.63
	Primary Care Physician	*$22.02*		
	Non-Primary Care Physician	*$107.61*		
Outpatient		$39.37	$17.90	$57.27
	DRG Outpatient	*$38.05*		
	A & B Outpatient	*$1.32*		
	Other Outpatient	*$0.00*		
Inpatient		$23.47	$11.05	$34.52
	DRG Inpatient	*$23.47*		
	A & B Inpatient	*$0.00*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$19.27	$0.00	$19.27
Chemical Dependency		$7.66	$0.00	$7.66
Primary Care Patient Centered Home		$27.44	$0.00	$27.44
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$8.75	$0.00	$8.75
Mental Health Services		$8.94	$0.79	$9.73
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$264.54	$29.74	$294.28

	Unadjusted	**$264.54**
	Base HRA Adjustment	**$29.74**
	Hospital Administrative Allowance	**$20.17**
	Admin	**$28.68**
Total Services with Admin		**$343.12**
	Admin %	8.36%
% (Admin + Hospital Administrative Allowance)		14.23%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $49.90

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-County
Rate Group:	**Children 0-1 (CHIP, PLMC, TANF Children)**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$96.07	$0.00	$96.07
	Primary Care Physician	*$37.29*		
	Non-Primary Care Physician	*$58.78*		
Outpatient		$35.53	$16.52	$52.05
	DRG Outpatient	*$35.10*		
	A & B Outpatient	*$0.43*		
	Other Outpatient	*$0.00*		
Inpatient		$224.00	$104.87	$328.87
	DRG Inpatient	*$222.84*		
	A & B Inpatient	*$1.16*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$9.45	$0.00	$9.45
Chemical Dependency		$0.00	$0.00	$0.00
Primary Care Patient Centered Home		$12.61	$0.00	$12.61
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$3.93	$0.00	$3.93
Mental Health Services		$0.02	$0.00	$0.02
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$381.63	$121.38	$503.01

	Unadjusted	**$381.63**
	Base HRA Adjustment	**$121.38**
	Hospital Administrative Allowance	**$34.90**
	Admin	**$43.84**
Total Services with Admin		**$581.75**
	Admin %	7.54%
% (Admin + Hospital Administrative Allowance)		13.54%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $156.29

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	$26.80	$0.00	$26.80
Primary Care Physician	*$11.51*		
Non-Primary Care Physician	*$15.29*		
Outpatient	$20.95	$9.64	$30.59
DRG Outpatient	*$20.49*		
A & B Outpatient	*$0.46*		
Other Outpatient	*$0.00*		
Inpatient	$12.05	$5.65	$17.70
DRG Inpatient	*$12.00*		
A & B Inpatient	*$0.05*		
Other Inpatient	*$0.00*		
Prescription Drugs	$6.04	$0.00	$6.04
Chemical Dependency	$0.00	$0.00	$0.00
Primary Care Patient Centered Home	$3.38	$0.00	$3.38
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$2.14	$0.00	$2.14
Mental Health Services	$3.57	$0.02	$3.59
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$74.93	$15.31	$90.24

	Unadjusted	**$74.93**
	Base HRA Adjustment	**$15.31**
	Hospital Administrative Allowance	**$6.07**
	Admin	**$8.34**
Total Services with Admin		**$104.64**
	Admin %	7.97%
% (Admin + Hospital Administrative Allowance)		13.77%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $21.38

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	$17.90	$0.00	$17.90
Primary Care Physician	*$7.20*		
Non-Primary Care Physician	*$10.70*		
Outpatient	$14.68	$6.68	$21.36
DRG Outpatient	*$14.20*		
A & B Outpatient	*$0.49*		
Other Outpatient	*$0.00*		
Inpatient	$8.84	$4.10	$12.95
DRG Inpatient	*$8.72*		
A & B Inpatient	*$0.12*		
Other Inpatient	*$0.00*		
Prescription Drugs	$9.33	$0.00	$9.33
Chemical Dependency	$0.29	$0.00	$0.29
Primary Care Patient Centered Home	$2.88	$0.00	$2.88
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$2.50	$0.00	$2.50
Mental Health Services	$19.26	$0.77	$20.03
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$75.69	$11.56	$87.24

	Unadjusted	**$75.69**
	Base HRA Adjustment	**$11.56**
	Hospital Administrative Allowance	**$4.99**
	Admin	**$8.29**
Total Services with Admin		**$100.52**
	Admin %	8.25%
% (Admin + Hospital Administrative Allowance)		13.21%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $16.54

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-County
Rate Group:	**ABAD with Medicare**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	$22.11	$0.00	$22.11
Primary Care Physician	*$6.79*		
Non-Primary Care Physician	*$15.33*		
Outpatient	$22.46	$10.39	$32.86
DRG Outpatient	*$22.09*		
A & B Outpatient	*$0.38*		
Other Outpatient	*$0.00*		
Inpatient	$20.97	$0.02	$20.99
DRG Inpatient	*$20.95*		
A & B Inpatient	*$0.02*		
Other Inpatient	*$0.00*		
Prescription Drugs	$8.57	$0.00	$8.57
Chemical Dependency	$8.24	$0.00	$8.24
Primary Care Patient Centered Home	$4.81	$0.00	$4.81
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$26.31	$0.00	$26.31
Mental Health Services	$68.54	$0.01	$68.55
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$182.02	$10.42	$192.44

	Unadjusted	**$182.02**
	Base HRA Adjustment	**$10.42**
	Hospital Administrative Allowance	**$9.64**
	Admin	**$19.38**
Total Services with Admin		**$221.46**
	Admin %	8.75%
% (Admin + Hospital Administrative Allowance)		13.10%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $20.06

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-County
Rate Group:	**ABAD without Medicare**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$103.73	$0.00	$103.73
	Primary Care Physician	*$29.48*		
	Non-Primary Care Physician	*$74.25*		
Outpatient		$145.48	$67.57	$213.06
	DRG Outpatient	*$143.59*		
	A & B Outpatient	*$1.89*		
	Other Outpatient	*$0.00*		
Inpatient		$215.99	$101.26	$317.25
	DRG Inpatient	*$215.18*		
	A & B Inpatient	*$0.81*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$158.47	$0.00	$158.47
Chemical Dependency		$13.93	$0.00	$13.93
Primary Care Patient Centered Home		$25.62	$0.00	$25.62
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$89.94	$0.00	$89.94
Mental Health Services		$113.44	$12.95	$126.39
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$866.61	$181.78	$1,048.39

	Unadjusted	**$866.61**
	Base HRA Adjustment	**$181.78**
	Hospital Administrative Allowance	**$67.80**
	Admin	**$96.55**
Total Services with Admin		**$1,212.73**
	Admin %	7.96%
% (Admin + Hospital Administrative Allowance)		13.55%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $249.58

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-County
Rate Group:	**OAA with Medicare**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	$18.11	$0.00	$18.11
Primary Care Physician	*$7.71*		
Non-Primary Care Physician	*$10.40*		
Outpatient	$18.23	$8.48	$26.71
DRG Outpatient	*$18.01*		
A & B Outpatient	*$0.22*		
Other Outpatient	*$0.00*		
Inpatient	$40.23	$0.01	$40.24
DRG Inpatient	*$40.00*		
A & B Inpatient	*$0.24*		
Other Inpatient	*$0.00*		
Prescription Drugs	$5.51	$0.00	$5.51
Chemical Dependency	$1.08	$0.00	$1.08
Primary Care Patient Centered Home	$5.25	$0.00	$5.25
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$33.37	$0.00	$33.37
Mental Health Services	$8.37	$0.00	$8.37
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$130.15	$8.49	$138.64

	Unadjusted	**$130.15**
	Base HRA Adjustment	**$8.49**
	Hospital Administrative Allowance	**$9.24**
	Admin	**$13.91**
Total Services with Admin		**$161.79**
	Admin %	8.60%
% (Admin + Hospital Administrative Allowance)		14.31%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $17.72

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **OAA without Medicare**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	$103.73	$0.00	$103.73
Primary Care Physician	*$29.48*		
Non-Primary Care Physician	*$74.25*		
Outpatient	$145.48	$67.57	$213.06
DRG Outpatient	*$143.59*		
A & B Outpatient	*$1.89*		
Other Outpatient	*$0.00*		
Inpatient	$215.99	$101.26	$317.25
DRG Inpatient	*$215.18*		
A & B Inpatient	*$0.81*		
Other Inpatient	*$0.00*		
Prescription Drugs	$158.47	$0.00	$158.47
Chemical Dependency	$13.93	$0.00	$13.93
Primary Care Patient Centered Home	$25.62	$0.00	$25.62
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$89.94	$0.00	$89.94
Mental Health Services	$113.44	$12.95	$126.39
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$866.61	$181.78	$1,048.39

	Unadjusted	**$866.61**
	Base HRA Adjustment	**$181.78**
	Hospital Administrative Allowance	**$67.80**
	Admin	**$96.55**
Total Services with Admin		**$1,212.74**
	Admin %	7.96%
% (Admin + Hospital Administrative Allowance)		13.55%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $249.58

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **Foster Children (CAF)**

	Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician	*$33.12*	$0.00	$33.12
Primary Care Physician	*$13.89*		
Non-Primary Care Physician	*$19.22*		
Outpatient	*$27.74*	$12.43	$40.17
DRG Outpatient	*$26.42*		
A & B Outpatient	*$1.32*		
Other Outpatient	*$0.00*		
Inpatient	*$14.37*	$6.76	$21.13
DRG Inpatient	*$14.37*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Prescription Drugs	$39.44	$0.00	$39.44
Chemical Dependency	$1.77	$0.00	$1.77
Primary Care Patient Centered Home	$5.09	$0.00	$5.09
Case Management or ENCC	$0.00	$0.00	$0.00
DME and Miscellaneous	$5.67	$0.00	$5.67
Children's Wraparound	$10.64	$0.00	$10.64
Mental Health Services	$242.42	$4.85	$247.27
Dental Services	$0.00	$0.00	$0.00
Total Basic Services	$380.24	$24.04	$404.29

	Unadjusted	**$380.24**
	Base HRA Adjustment	**$24.04**
	Hospital Administrative Allowance	**$12.97**
	Admin	**$40.48**
Total Services with Admin		**$457.74**
	Admin %	8.84%
% (Admin + Hospital Administrative Allowance)		11.68%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $37.01

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-County
Rate Group:	**OHP Standard - Families**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$62.69	$0.00	$62.69
	Primary Care Physician	*$19.60*		
	Non-Primary Care Physician	*$43.09*		
Outpatient		$55.55	$25.02	$80.58
	DRG Outpatient	*$53.18*		
	A & B Outpatient	*$2.38*		
	Other Outpatient	*$0.00*		
Inpatient		$29.90	$13.75	$43.65
	DRG Inpatient	*$29.22*		
	A & B Inpatient	*$0.68*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$33.43	$0.00	$33.43
Chemical Dependency		$7.89	$0.00	$7.89
Primary Care Patient Centered Home		$8.48	$0.00	$8.48
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$8.80	$0.00	$8.80
Mental Health Services		$11.89	$0.81	$12.70
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$218.65	$39.58	$258.23

	Unadjusted	**$218.65**
	Base HRA Adjustment	**$39.58**
	Hospital Administrative Allowance	**$17.39**
	Admin	**$24.17**
Total Services with Admin		**$299.79**
	Admin %	8.06%
% (Admin + Hospital Administrative Allowance)		13.86%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $56.97

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
September 2012 through December 2013

Plan: Tri-County Medicaid Collaborative
Plan ID:
Region: Tri-County
Rate Group: **OHP Standard - Adults and Couples**

		Unadjusted Capitation Rate	Base Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Physician		$83.74	$0.00	$83.74
	Primary Care Physician	*$24.25*		
	Non-Primary Care Physician	*$59.49*		
Outpatient		$82.31	$37.64	$119.95
	DRG Outpatient	*$79.98*		
	A & B Outpatient	*$2.33*		
	Other Outpatient	*$0.00*		
Inpatient		$74.48	$34.68	$109.16
	DRG Inpatient	*$73.69*		
	A & B Inpatient	*$0.80*		
	Other Inpatient	*$0.00*		
Prescription Drugs		$64.00	$0.00	$64.00
Chemical Dependency		$27.57	$0.00	$27.57
Primary Care Patient Centered Home		$17.10	$0.00	$17.10
Case Management or ENCC		$0.00	$0.00	$0.00
DME and Miscellaneous		$17.07	$0.00	$17.07
Mental Health Services		$37.08	$3.81	$40.89
Dental Services		$0.00	$0.00	$0.00
Total Basic Services		$403.36	$76.12	$479.49

	Unadjusted	**$403.36**
	Base HRA Adjustment	**$76.12**
	Hospital Administrative Allowance	**$31.67**
	Admin	**$44.68**
Total Services with Admin		**$555.83**
	Admin %	8.04%
% (Admin + Hospital Administrative Allowance)		13.74%

Total HRA (Base HRA Adjustment + Hospital Administrative Allowance) $107.79

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Temporary Assistance to Needy Families - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$17.29	$0.00	$17.29
Inpatient	$3.95	$0.72	$4.67
DRG Inpatient	*$3.40*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.55*		
Total Basic Services	$21.24	$0.72	$21.96

Unadjusted	**$21.24**
HRA Adjustment	**$0.72**
Admin	**$2.89**
Total Services with Admin	**$24.85**
Admin %	11.62%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Poverty Level Medical - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$4.93	$0.00	$4.93
Inpatient	$0.97	$0.16	$1.13
DRG Inpatient	*$0.97*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$5.89	$0.16	$6.06

	Unadjusted	**$5.89**
	HRA Adjustment	**$0.16**
	Admin	**$0.80**
Total Services with Admin		**$6.86**
Admin %		11.68%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Children 0-1 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$0.37	$0.00	$0.37
Inpatient	$0.02	$0.00	$0.02
DRG Inpatient	*$0.02*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$0.39	$0.00	$0.39

	Unadjusted	**$0.39**
	HRA Adjustment	**$0.00**
	Admin	**$0.05**
Total Services with Admin		**$0.44**
Admin %		11.85%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Children 1-5 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$4.06	$0.00	$4.06
Inpatient	$0.01	$0.02	$0.03
DRG Inpatient	*$0.01*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$4.07	$0.02	$4.09

	Unadjusted	**$4.07**
	HRA Adjustment	**$0.02**
	Admin	**$0.55**
Total Services with Admin		**$4.64**
Admin %		11.87%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Children 6-18 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$27.11	$0.00	$27.11
Inpatient	$2.46	$0.45	$2.91
DRG Inpatient	*$2.46*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$29.57	$0.45	$30.02

Unadjusted	**$29.57**
HRA Adjustment	**$0.45**
Admin	**$4.03**
Total Services with Admin	**$34.05**
Admin %	11.84%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**ABAD with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$42.88	$0.00	$42.88
Inpatient	$5.61	$0.00	$5.61
DRG Inpatient	*$5.61*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$48.48	$0.00	$48.48

Unadjusted	**$48.48**
HRA Adjustment	**$0.00**
Admin	**$6.54**
Total Services with Admin	**$55.03**
Admin %	11.89%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**ABAD without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$81.93	$0.00	$81.93
Inpatient	$27.58	$5.10	$32.69
DRG Inpatient	*$27.48*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.10*		
Total Basic Services	$109.52	$5.10	$114.62

	Unadjusted	**$109.52**
	HRA Adjustment	**$5.10**
	Admin	**$14.96**
Total Services with Admin		**$129.58**
Admin %		11.54%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**OAA with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$3.94	$0.00	$3.94
Inpatient	$0.39	$0.00	$0.39
DRG Inpatient	*$0.39*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$4.33	$0.00	$4.33

	Unadjusted	**$4.33**
	HRA Adjustment	**$0.00**
	Admin	**$0.58**
Total Services with Admin		**$4.91**
Admin %		11.89%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**OAA without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$16.99	$0.00	$16.99
Inpatient	$0.00	$1.11	$1.11
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$16.99	$1.11	$18.10

Unadjusted	**$16.99**
HRA Adjustment	**$1.11**
Admin	**$0.21**
Total Services with Admin	**$18.31**
Admin %	1.12%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**Foster Children (CAF)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$157.81	$0.00	$157.81
Inpatient	$9.48	$1.03	$10.52
DRG Inpatient	*$9.48*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$167.29	$1.03	$168.32

	Unadjusted	**$167.29**
	HRA Adjustment	**$1.03**
	Admin	**$23.02**
Total Services with Admin		**$191.34**
Admin %		12.03%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**OHP Standard - Families**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$9.83	$0.00	$9.83
Inpatient	$0.24	$0.33	$0.57
DRG Inpatient	*$0.16*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.08*		
Total Basic Services	$10.07	$0.33	$10.40

	Unadjusted	**$10.07**
	HRA Adjustment	**$0.33**
	Admin	**$1.36**
Total Services with Admin		**$11.76**
Admin %		11.56%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Clackamas
Rate Group:	**OHP Standard - Adults and Couples**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$22.75	$0.00	$22.75
Inpatient	$7.20	$1.40	$8.60
DRG Inpatient	*$6.80*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.40*		
Total Basic Services	$29.95	$1.40	$31.35

	Unadjusted	**$29.95**
	HRA Adjustment	**$1.40**
	Admin	**$4.03**
Total Services with Admin		**$35.38**
Admin %		11.40%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Temporary Assistance to Needy Families - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$16.40	$0.00	$16.40
Inpatient	$5.60	$0.75	$6.35
DRG Inpatient	*$5.60*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$22.00	$0.75	$22.75

Unadjusted	**$22.00**
HRA Adjustment	**$0.75**
Admin	**$2.38**
Total Services with Admin	**$25.12**
Admin %	9.46%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Poverty Level Medical - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$12.06	$0.00	$12.06
Inpatient	$5.35	$0.47	$5.82
DRG Inpatient	*$5.35*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$17.40	$0.47	$17.88

Unadjusted	**$17.40**
HRA Adjustment	**$0.47**
Admin	**$1.01**
Total Services with Admin	**$18.89**
Admin %	5.34%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Children 0-1 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$0.79	$0.00	$0.79
Inpatient	$0.78	$0.01	$0.79
DRG Inpatient	*$0.78*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$1.57	$0.01	$1.58

Unadjusted	**$1.57**
HRA Adjustment	**$0.01**
Admin	**$0.07**
Total Services with Admin	**$1.64**
Admin %	4.05%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Children 1-5 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$2.89	$0.00	$2.89
Inpatient	$0.00	$0.01	$0.01
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$2.89	$0.01	$2.90

Unadjusted	**$2.89**
HRA Adjustment	**$0.01**
Admin	**$0.41**
Total Services with Admin	**$3.31**
Admin %	12.48%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Children 6-18 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$16.14	$0.00	$16.14
Inpatient	$1.33	$0.27	$1.60
DRG Inpatient	*$1.33*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$17.47	$0.27	$17.74

Unadjusted	**$17.47**
HRA Adjustment	**$0.27**
Admin	**$1.95**
Total Services with Admin	**$19.69**
Admin %	9.92%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**ABAD with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$62.34	$0.00	$62.34
Inpatient	$5.12	$0.00	$5.12
DRG Inpatient	*$5.12*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$67.46	$0.00	$67.46

Unadjusted	**$67.46**
HRA Adjustment	**$0.00**
Admin	**$8.13**
Total Services with Admin	**$75.58**
Admin %	10.75%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**ABAD without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$74.26	$0.00	$74.26
Inpatient	$39.42	$5.30	$44.72
DRG Inpatient	*$39.42*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$113.68	$5.30	$118.98

Unadjusted	**$113.68**
HRA Adjustment	**$5.30**
Admin	**$13.47**
Total Services with Admin	**$132.45**
Admin %	10.17%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**OAA with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$8.69	$0.00	$8.69
Inpatient	$0.81	$0.00	$0.81
DRG Inpatient	*$0.81*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$9.50	$0.00	$9.50

Unadjusted	**$9.50**
HRA Adjustment	**$0.00**
Admin	**$0.83**
Total Services with Admin	**$10.33**
Admin %	8.06%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**OAA without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$9.82	$0.00	$9.82
Inpatient	$0.00	$0.64	$0.64
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$9.82	$0.64	$10.46

Unadjusted	**$9.82**
HRA Adjustment	**$0.64**
Admin	**$2.50**
Total Services with Admin	**$12.96**
Admin %	19.30%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**Foster Children (CAF)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$188.45	$0.00	$188.45
Inpatient	$8.13	$1.22	$9.35
DRG Inpatient	*$8.13*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$196.58	$1.22	$197.80

Unadjusted	**$196.58**
HRA Adjustment	**$1.22**
Admin	**$20.06**
Total Services with Admin	**$217.86**
Admin %	9.21%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**OHP Standard - Families**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$10.13	$0.00	$10.13
Inpatient	$2.04	$0.40	$2.44
DRG Inpatient	*$1.96*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.08*		
Total Basic Services	$12.17	$0.40	$12.57

Unadjusted	**$12.17**
HRA Adjustment	**$0.40**
Admin	**$1.28**
Total Services with Admin	**$13.85**
Admin %	9.22%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Multnomah
Rate Group:	**OHP Standard - Adults and Couples**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$27.23	$0.00	$27.23
Inpatient	$22.80	$2.34	$25.13
DRG Inpatient	*$22.40*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.40*		
Total Basic Services	$50.03	$2.34	$52.36

Unadjusted	**$50.03**
HRA Adjustment	**$2.34**
Admin	**$4.42**
Total Services with Admin	**$56.78**
Admin %	7.78%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Temporary Assistance to Needy Families - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$11.64	$0.00	$11.64
Inpatient	$5.60	$0.59	$6.19
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$5.60*		
Total Basic Services	$17.24	$0.59	$17.83

Unadjusted	**$17.24**
HRA Adjustment	**$0.59**
Admin	**$2.67**
Total Services with Admin	**$20.49**
Admin %	13.01%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Poverty Level Medical - Adults**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$4.27	$0.00	$4.27
Inpatient	$2.27	$0.18	$2.45
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$2.27*		
Total Basic Services	$6.53	$0.18	$6.71

Unadjusted	**$6.53**
HRA Adjustment	**$0.18**
Admin	**$1.01**
Total Services with Admin	**$7.72**
Admin %	13.09%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Children 0-1 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$0.06	$0.00	$0.06
Inpatient	$0.00	$0.00	$0.00
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.00*		
Total Basic Services	$0.06	$0.00	$0.06

	Unadjusted	**$0.06**
	HRA Adjustment	**$0.00**
	Admin	**$0.01**
Total Services with Admin		**$0.07**
Admin %		15.09%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Children 1-5 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$2.12	$0.00	$2.12
Inpatient	$0.03	$0.01	$0.04
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.03*		
Total Basic Services	$2.15	$0.01	$2.16

	Unadjusted	**$2.15**
	HRA Adjustment	**$0.01**
	Admin	**$0.34**
Total Services with Admin		**$2.49**
Admin %		13.45%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Children 6-18 (CHIP, PLMC, TANF Children)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$13.81	$0.00	$13.81
Inpatient	$2.38	$0.25	$2.63
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$2.38*		
Total Basic Services	$16.19	$0.25	$16.44

Unadjusted	**$16.19**
HRA Adjustment	**$0.25**
Admin	**$2.54**
Total Services with Admin	**$18.98**
Admin %	13.41%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**ABAD with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$53.40	$0.00	$53.40
Inpatient	$5.27	$0.00	$5.27
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$5.27*		
Total Basic Services	$58.67	$0.00	$58.67

	Unadjusted	**$58.67**
	HRA Adjustment	**$0.00**
	Admin	**$8.50**
Total Services with Admin		**$67.17**
Admin %		12.66%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**ABAD without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$78.60	$0.00	$78.60
Inpatient	$30.30	$5.07	$35.37
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$30.30*		
Total Basic Services	$108.89	$5.07	$113.97

Unadjusted	**$108.89**
HRA Adjustment	**$5.07**
Admin	**$15.75**
Total Services with Admin	**$129.72**
Admin %	12.14%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**OAA with Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$6.51	$0.00	$6.51
Inpatient	$0.84	$0.00	$0.84
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$0.84*		
Total Basic Services	$7.35	$0.00	$7.35

	Unadjusted	**$7.35**
	HRA Adjustment	**$0.00**
	Admin	**$1.12**
Total Services with Admin		**$8.47**
Admin %		13.27%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**OAA without Medicare**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$2.84	$0.00	$2.84
Inpatient	$2.69	$0.36	$3.05
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$2.69*		
Total Basic Services	$5.53	$0.36	$5.89

	Unadjusted	**$5.53**
	HRA Adjustment	**$0.36**
	Admin	**$0.86**
Total Services with Admin		**$6.76**
Admin %		12.80%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**Foster Children (CAF)**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$273.16	$0.00	$273.16
Inpatient	$20.66	$1.88	$22.54
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$20.66*		
Children's Wraparound	$41.73	$0.00	$41.73
Total Basic Services	$335.55	$1.88	$337.43

	Unadjusted	**$335.55**
	HRA Adjustment	**$1.88**
	Admin	**$47.07**
Total Services with Admin		**$384.50**
Admin %		12.24%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**OHP Standard - Families**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$9.16	$0.00	$9.16
Inpatient	$2.15	$0.37	$2.52
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$2.15*		
Total Basic Services	$11.31	$0.37	$11.68

	Unadjusted	**$11.31**
	HRA Adjustment	**$0.37**
	Admin	**$1.73**
Total Services with Admin		**$13.42**
Admin %		12.91%

Oregon Health Plan Medicaid Demonstration

Capitation Rates for September 2012 through December 2013

Mental health Services Only

Plan:	Tri-County Medicaid Collaborative
Plan ID:	
Region:	Tri-county - Washington
Rate Group:	**OHP Standard - Adults and Couples**

	Unadjusted Capitation Rate	Hospital Reimbursement Adjustment	Adjusted Capitation Rate
Non-Inpatient	$21.93	$0.00	$21.93
Inpatient	$8.58	$1.42	$10.00
DRG Inpatient	*$0.00*		
A & B Inpatient	*$0.00*		
Other Inpatient	*$8.58*		
Total Basic Services	$30.51	$1.42	$31.93

	Unadjusted	**$30.51**
	HRA Adjustment	**$1.42**
	Admin	**$4.67**
Total Services with Admin		**$36.60**
Admin %		12.75%

Exhibit D – Standard Terms and Conditions

1. Governing Law, Consent to Jurisdiction

This Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding (collectively, the "claim") between OHA (or any other agency or department of the State of Oregon) and Contractor that arises from or relates to this Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. **CONTRACTOR, BY EXECUTION OF THIS CONTRACT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.**

2. Compliance with Applicable Law

a. Contractor shall comply and cause all Subcontractors to comply with all State and local laws, regulations, executive orders and ordinances applicable to this Contract or to the performance of Work as they may be adopted, amended or repealed from time to time, including but not limited to the following: (i) ORS Chapter 659A.142; (ii) OHA rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; (iii) all other OHA Rules in OAR Chapter 410; and (iv) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. OHA's performance under this Contract is conditioned upon Contractor's compliance with the provisions of ORS 279B.220, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).

b. In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Contractor under this Contract to Clients, including Medicaid-Eligible Individuals, shall, at the request of such Clients, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. OHA shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall cause all Subcontractors under this Contract to comply with the requirements of this provision.

c. Contractor shall comply with the federal laws as set forth or incorporated, or both, in this Contract and all other federal laws, applicable to Contractor's performance under this Contract as they may be adopted, amended or repealed from time to time.

3. Independent Contractor

a. Contractor is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

b. If Contractor is currently performing work for the State of Oregon or the federal government, Contractor by signature to this Contract, represents and warrants that Contractor's Work to be performed under this Contract creates 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 for which Contractor currently performs work would prohibit Contractor's Work under this Contract. If compensation under this Contract is to be charged against federal funds, Contractor certifies that it is not currently employed by the federal government.

c. Contractor is responsible for all federal and State taxes applicable to compensation paid to Contractor under this Contract and, unless Contractor is subject to backup withholding, OHA will not withhold from such compensation any amounts to cover Contractor's federal or State tax obligations. Contractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Contractor under this Contract, except as a self-employed individual.

d. Contractor shall perform all Work as an independent contractor. OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product, however, OHA may not and will not control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work.

4. Representations and Warranties

a. Contractor's Representations and Warranties. Contractor represents and warrants to OHA that:

(1) Contractor has the power and authority to enter into and perform this Contract,

(2) This Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms,

(3) Contractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Contractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Contractor's industry, trade or profession,

(4) Contractor shall, at all times during the term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work, and

(5) Contractor prepared its application related to this Contract, if any, independently from all other applicants, and without collusion, fraud, or other dishonesty.

b. Warranties cumulative. The warranties set forth in this section are in addition to, and not in lieu of, any other warranties provided.

5. (Reserved)

6. Funds Available and Authorized

a. Contractor shall not be compensated for Work performed under this Contract by any other agency or department of the State of Oregon or the federal government. OHA certifies that it has sufficient funds currently authorized for expenditure to finance costs of this Contract within OHA's current biennial appropriation or limitation. Contractor understands and agrees that OHA's payment for Work performed is contingent on OHA receiving appropriations, limitations, allotments, or other expenditure authority sufficient to allow OHA, in the exercise of its reasonable discretion, to continue to make payments under this Contract.

b. All billings and payments processed through the Medicaid Management Information System (MMIS) shall be processed in accordance with the provisions of Oregon Administrative Rules (OAR) 407-120-0100 through 407-120-0200, OAR 407-120-0300 through OAR 407-120-0380 and any other OHA Oregon Administrative Rules that are program specific to the billings and payments and, if applicable, to billing and payment of Medicaid services.

7. Recovery of Overpayments

IF PAYMENTS UNDER THIS CONTRACT, OR UNDER ANY OTHER CONTRACT BETWEEN CONTRACTOR AND OHA, RESULT IN PAYMENTS TO CONTRACTOR TO WHICH CONTRACTOR IS NOT ENTITLED, OHA, AFTER GIVING WRITTEN NOTIFICATION TO CONTRACTOR, MAY WITHHOLD FROM PAYMENTS DUE TO CONTRACTOR SUCH AMOUNTS, OVER SUCH PERIODS OF TIME, AS ARE NECESSARY TO RECOVER THE AMOUNT OF THE OVERPAYMENT UNLESS CONTRACTOR PROVIDES A WRITTEN OBJECTION WITHIN 14 CALENDAR DAYS FROM THE DATE OF THE NOTICE. ABSENT TIMELY WRITTEN OBJECTION, CONTRACTOR HEREBY REASSIGNS TO OHA ANY RIGHT CONTRACTOR MAY HAVE TO RECEIVE SUCH PAYMENTS. IF CONTRACTOR PROVIDES A TIMELY WRITTEN OBJECTION TO OHA'S WITHHOLDING OF SUCH PAYMENTS, THE PARTIES AGREE TO CONFER IN GOOD FAITH REGARDING THE NATURE AND AMOUNT OF THE OVERPAYMENT IN DISPUTE AND THE MANNER IN WHICH THE OVERPAYMENT IS TO BE REPAID. OHA RESERVES ITS RIGHT TO PURSUE ANY OR ALL OF THE REMEDIES AVAILABLE TO IT UNDER THIS CONTRACT AND AT LAW OR IN EQUITY INCLUDING OHA'S RIGHT TO SETOFF.

8. (Reserved)

9. Indemnification

a. GENERAL INDEMNITY. CONTRACTOR SHALL DEFEND, 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 REASONABLE ATTORNEYS' FEES AND EXPENSES AT TRIAL, ON APPEAL AND IN CONNECTION WITH ANY PETITION FOR REVIEW) RESULTING FROM, ARISING OUT OF, OR RELATING TO THE ACTIVITIES OF CONTRACTOR OR ITS OFFICERS, EMPLOYEES, SUBCONTRACTORS, OR AGENTS UNDER THIS CONTRACT.

b. CONTROL OF DEFENSE AND SETTLEMENT. CONTRACTOR SHALL HAVE CONTROL OF THE DEFENSE AND SETTLEMENT OF ANY CLAIM THAT IS SUBJECT TO THIS SECTION a., ABOVE; HOWEVER, NEITHER CONTRACTOR NOR ANY ATTORNEY ENGAGED BY CONTRACTOR, SHALL DEFEND THE CLAIM IN THE NAME OF THE STATE OF OREGON OR ANY AGENCY OF THE STATE OF OREGON, NOR PURPORT TO ACT AS LEGAL REPRESENTATIVE OF THE STATE OF OREGON OR ANY OF ITS AGENCIES, WITHOUT FIRST RECEIVING FROM THE ATTORNEY GENERAL AUTHORITY TO ACT AS LEGAL COUNSEL FOR THE STATE OF OREGON; NOR SHALL CONTRACTOR SETTLE ANY CLAIM ON BEHALF OF THE STATE OF OREGON WITHOUT THE

APPROVAL OF THE ATTORNEY GENERAL. THE STATE OF OREGON MAY, AT ITS ELECTION AND EXPENSE, ASSUME ITS OWN DEFENSE AND SETTLEMENT IN THE EVENT THAT THE STATE OF OREGON DETERMINES THAT CONTRACTOR IS PROHIBITED FROM DEFENDING THE STATE OF OREGON, OR IS NOT ADEQUATELY DEFENDING THE STATE OF OREGON'S INTERESTS, OR THAT AN IMPORTANT GOVERNMENTAL PRINCIPLE IS AT ISSUE, AND THE STATE OF OREGON DESIRES TO ASSUME ITS OWN DEFENSE.

c. TO THE EXTENT PERMITTED BY ARTICLE XI, SECTION 7 OF THE OREGON CONSTITUTION AND BY OREGON TORT CLAIMS ACT, THE STATE OF OREGON SHALL INDEMNIFY, WITHIN THE LIMITS OF THE TORT CLAIMS ACT, CONTRACTOR AGAINST LIABILITY FOR DAMAGE TO LIFE OR PROPERTY ARISING FROM THE STATE'S ACTIVITY UNDER THIS CONTRACT, PROVIDED THE STATE SHALL NOT BE REQUIRED TO INDEMNIFY CONTRACTOR FOR ANY SUCH LIABILITY ARISING OUT OF THE WRONGFUL ACTS OF EMPLOYEES, SUBCONTRACTORS OR AGENTS OF CONTRACTOR.

d. THE OBLIGATIONS OF THIS SECTION 9 ARE SUBJECT TO THE LIMITATIONS IN SECTION 11 OF THIS EXHIBIT.

10. Default; Remedies; and Termination

a. Default by Contractor. Contractor shall be in default under this Contract if:

(1) Contractor institutes or has instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

(2) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Contract and Contractor has not obtained such license or certificate within 14 calendar days after OHA's notice or such longer period as OHA may specify in such notice; or

(3) Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and such breach, default or failure is not cured within 14 calendar days after OHA's notice, or such longer period as OHA may specify in such notice; or

(4) Contractor knowingly has a director, officer, partner or person with beneficial ownership of more than 5% of Contractor's equity or has an employment, consulting or other Subcontractor agreement for the provision of items and services that are significant and material to Contractor's obligations under this Contract, concerning whom:

(a) Any license or certificate required by law or regulation to be held by Contractor or Subcontractor to provide services required by this Contract is for any reason denied, revoked or not renewed; or

(b) Is suspended, debarred or otherwise excluded from participating in procurement activities under Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(c) Is suspended or terminated from the Medical Assistance Program or excluded from participation in the Medicare program; or

(d) Is convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws (or entered a plea of nolo contendere).

(5) If OHA determines that health or welfare of Members is in jeopardy if this Contract continues; or

(6) If OHA Determines:

(a) That amendment of this Contract is required due to change(s) in federal or State law or regulations, or due to changes in Covered Services or CCO Payments under ORS 414.735;

(b) That failure to amend this Contract to execute those changes in the time and manner proposed in the amendment may place OHA at risk of non-compliance with federal or State statute or regulations or changes required by the Legislative Assembly or the Legislative Emergency Board;

(c) That Contractor does not accept the amendment; or

(d) That Contractor failed to execute the amendment to this Contract within the time allowed.

b. OHA's Remedies for Contractor's Default. In the event Contractor is in default under Section 10.a., above, OHA may, at its option, pursue any or all of the remedies available to it under this Contract and at law or in equity, including, but not limited to:

(1) Termination of this Contract under Section 10.e.(2) below;

(2) Withholding all monies due for Work and Work Products that Contractor has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

(3) Sanctions under Exhibit D, Section 32 through 35 of this Contract;

(4) Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief; and

(5) Exercise of its right of recovery of overpayments under Section 7 of this Exhibit or setoff or both.

These remedies are cumulative to the extent the remedies are not inconsistent, and OHA may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever. If a court determines that Contractor was not in default under Section 10.a. above, then Contractor shall be entitled to a Claim for any unpaid CCO Payments as identified in Exhibit C, less previous amounts paid and any claim(s) that OHA has against Contractor.

c. Default by OHA. OHA shall be in default under this Contract if:

(1) OHA fails to pay Contractor any amount pursuant to the terms of this Contract, net of any reduction for overpayment or other offset, and OHA fails to cure such failure within 15 calendar days after delivery of Contractor's notice of such failure to pay or such longer period as Contractor may specify in such notice; or

(2) OHA commits any material breach or default of any covenant, warranty, or obligation under this Contract, and such breach or default is not cured within 30 calendar days after Contractor's notice or such longer period as Contractor may specify in such notice.

Any notice of default by Contractor must identify, with specificity, the term or terms of this Contract allegedly breached.

d. Contractor's Remedies for OHA's Default. In the event OHA terminates this Contract under Section 10.e.(1) below, or in the event OHA is in default under Section 10.c. above and whether or not Contractor elects to exercise its right to terminate this Contract under Section 10.e.(3) below, Contractor's sole remedy shall be a Claim for any unpaid CCO Payments as identified in Exhibit C less previous amounts paid and any claim(s) that OHA has against Contractor. If previous amounts paid to Contractor exceed the amount due to Contractor under this Section 10.d. Contractor shall immediately pay any excess to OHA upon written demand. If Contractor does not immediately pay the excess, OHA may recover the overpayment in accordance with Section 7. "Recovery of Overpayments" above, and may pursue any other remedy that may be available to it.

e. Termination

(1) OHA's Right to Terminate at its Discretion. At its sole discretion, OHA may terminate this Contract:

(a) Without cause upon 90 days' prior written notice by OHA to Contractor; or

(b) Immediately upon notice if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority sufficient to allow OHA, in the exercise of its reasonable discretion, to continue to make payments under this Contract; or

(c) Immediately upon written notice if federal or State laws, regulations, guidelines or CMS waiver terms are modified or interpreted in such a way that OHA's purchase or continued use of the Work or Work Products under this Contract is prohibited or OHA is prohibited from paying for such Work or Work Products from the planned funding source; or

(d) Immediately, and notwithstanding any claim Contractor may have under Section 15, "Force Majeure", upon written notice to Contractor if there is a threat to the health, safety or welfare of any Client, including any Medicaid eligible individual, under its care.

(2) OHA's Right to Terminate for Cause. In addition to any other rights and remedies OHA may have under this Contract, and subject to Section 10.e.(3), OHA shall issue notice to Contractor that OHA is terminating this Contract upon the occurrence of any of the following events:

(a) Contractor is in default under Section 10.a.(1) because Contractor institutes or has instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

(b) Contractor is in default under Section 10.a.(2) because Contractor no longer holds a license or certificate that is required for it to perform Work under the Contract and Contractor has not obtained such license or certificate; or

(c) Contractor is in default under Section 10.a.(3) because Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms.

(3) Before terminating this Contract under Section 10.e.(1) or (2), OHA will:

(a) Provide Contractor an opportunity to appeal the notice of intent to terminate pursuant to OAR 410-120-1560. In the event that no appeal process is available to Contractor under OAR 410-120-1560, then the Contract shall be terminated in accordance with the termination notice. Where termination is based on failure to comply with a Corrective Action and Contractor has had an Administrative Review on issues substantially similar to the basis for the termination decision, such Administrative Review is deemed to satisfy any requirement for a pre-termination hearing; and

(b) After the hearing or Administrative Review, give Contractor written notice of the decision affirming or reversing the proposed termination of this Contract and, for an affirming decision, the effective date of the termination; and

(c) After a decision affirming termination, give Members notice of the termination and information on their options for receiving Medicaid services following the effective date of the termination, consistent with 42 CFR 438.10; and

(d) After OHA notifies Contractor that it intends to terminate its Contract under Section 10.e.(1) or (2), OHA must give the affected Members written notice of OHA's intent to terminate this Contract and allow affected Members to disenroll immediately without cause.

(4) Contractor's Right to Terminate for Cause. Contractor may terminate this Contract if OHA is in default under Section 10.c. and fails to cure such default within the time specified therein.

(5) Contractor's Right to Terminate at its Discretion. At its sole discretion, Contractor may terminate this Contract without cause upon 90 days' prior written notice by Contractor to OHA.

(6) Mutual Termination. This Contract may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

(7) In the event of termination of this Contract, at the end of the term of this Contract if Contractor does not execute a new Contract or upon 90 day notice that Contractor does not intend to renew this Contract, the following provisions shall apply to ensure continuity of the Work by Contractor. Contractor shall ensure:

(a) Continuation of services to Members for the period in which a CCO Payment has been made, including inpatient admissions up until discharge;

(b) Orderly and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;

(c) Timely submission of information, reports and records, including encounter data, required to be provided to OHA during the term of this Contract;

(d) Timely payment of valid claims for services to Members for dates of service included in the Contract year; and

(e) If Contractor continues to provide services to a Member after the date of termination, OHA is only authorized to pay for services subject to OHA rules on a fee-for-service basis if the former Member is OHA eligible and not covered under any other OHA Contractor. If Contractor chooses to provide services to a former Member who is no longer OHP eligible, OHA shall have no responsibility to pay for such services.

(8) Upon termination, OHA shall conduct an accounting of CCO Payments paid or payable and Members enrolled during the month in which termination is effective and shall be accomplished as follows:

(a) Mid-Month Termination: For a termination of this Contract that occurs during mid-month, the CCO Payments for that month shall be apportioned on a daily basis. Contractor shall be entitled to CCO Payments for the period of time prior to the date of termination and OHA shall be entitled to a refund for the balance of the month.

(b) Responsibility for CCO Payment/Claims: Contractor is responsible for any and all Claims from Subcontractors or other Providers, including Emergency Service Providers, for Coordinated Care Services provided prior to the termination date.

(c) Notification of Outstanding OHA Claims: Contractor shall promptly notify OHA of any outstanding Claims for which OHA may owe, or be liable for, a fee-for-service payment(s), which are known to Contractor at the time of termination or when such new Claims incurred prior to termination are received. Contractor shall supply OHA with all information necessary for reimbursement of such Claims.

(d) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to encounter data for services received by Members during the period of this Contract. Contractor is responsible for submitting financial and other reports required during the period of this Contract.

(e) Withholding: Pending Completion of Contractual Obligations: OHA shall withhold 20% of the Contractor's last CCO Payment until Contractor has complied with all contractual obligations. OHA's determination of completion of Contractor's contractual obligations shall be no sooner than 6 months from the date of termination. Failure to complete said contractual obligations within a reasonable time period shall result in a forfeiture of the 20% withhold.

11. Limitation of Liabilities

a. **NEITHER PARTY SHALL BE LIABLE FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR RELATED TO THIS CONTRACT. NEITHER PARTY SHALL BE LIABLE FOR ANY DAMAGES OF ANY SORT ARISING SOLELY FROM THE TERMINATION OF THIS CONTRACT OR ANY PART HEREOF IN ACCORDANCE WITH ITS TERMS.**

b. Contractor shall ensure that OHA is not held liable for any of the following:

(1) Payment for Contractor's or any Subcontractor's debts or liabilities in the event of insolvency; or

(2) Coordinated Care Services authorized or required to be provided under this Contract.

12. Insurance

Contractor shall maintain insurance as set forth in Exhibit F.

13. Access to Records and Facilities

Contractor and subcontractors shall maintain all financial records related to this Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Contractor shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Contractor, whether in paper, electronic or other form, that are pertinent to this Contract in such a manner to clearly document Contractor's performance. All financial records, other records, books, documents, papers, plans, records of shipments and payments and writings of Contractor whether in paper, electronic or other form, that are pertinent to this Contract, are collectively referred to as "Records." Contractor acknowledges and agrees that OHA, the Secretary of State's Office, CMS, the Comptroller General of the United States, the Oregon Department of Justice Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Records to perform examinations and audits and make excerpts and transcripts. Contractor shall retain and keep accessible all Records for the longer of:

a. Six years following final payment and termination of this Contract;

b. The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapter 166; or

c. Until the conclusion of any audit, controversy or litigation arising out of or related to this Contract.

Contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. This right also includes timely and reasonable access to Contractor's personnel and Subcontractors for the purpose of interview and discussion related to such documents. The rights of access in this subsection are not limited to the required retention period, but shall last as long as the records are retained.

14. Information Privacy/Security/Access

If the Work performed under this Contract requires Contractor or, when allowed, its Subcontractor(s), to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Contractor access to such OHA Information Assets or Network and Information Systems, Contractor shall comply and require any Subcontractor(s) to which such access has been granted to comply with OAR 407-014-0300 through OAR 407-014-0320, as such rules may be revised from time to time. For purposes of this section, "Information Asset" and "Network and Information System" have the meaning set forth in OAR 407-014-0305, as such rule may be revised from time to time.

15. Force Majeure

a. Neither OHA nor Contractor shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, natural causes, government fiat, terrorist acts, other acts of political sabotage or war, which is beyond the reasonable control of OHA or Contractor, respectively. Each party shall, however, make all reasonable efforts to remove or eliminate such a cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Contract.

b. If the rendering of services or benefits under this Contract is delayed or made impractical due to any of the circumstances listed in Section 15.a., above, care may be deferred until after resolution of those circumstances except in the following situations:

(1) Care is needed for Emergency Services;

(2) Care is needed for Urgent Care Services; or

(3) Care is needed where there is a potential for a serious adverse medical consequence if treatment or diagnosis is delayed more than 30 calendar days.

c. If any of the circumstances listed in Section 15.a., above, disrupts normal execution of Contractor duties under this Contract, Contractor shall notify Members in writing of the situation and direct Members to bring serious health care needs to Contractor's attention.

The foregoing shall not excuse Contractor from performance under this Contract if, and to the extent, the cause of the force majeure event was reasonable foreseeable and a prudent professional in Contractor's profession would have taken commercially reasonable measures prior to the occurrence of the force majeure event to eliminate or minimize the effects of such force majeure event.

16. Foreign Contractor

If Contractor is not domiciled in or registered to do business in the State of Oregon, Contractor shall promptly provide to the Department of Revenue and the Secretary of State Corporation Division all information required by those agencies relative to this Contract.

17. Assignment of Contract, Successors in Interest

a. Contractor shall not assign or transfer its interest in this Contract, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as OHA may deem necessary, including but not limited to Exhibit B, Part 8, Section 14. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in the Contract.

b. The provisions of this Contract shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

18. Subcontracts

Contractor shall notify OHA, in writing, of any subcontract(s) for any of the Work required by this Contract other than information submitted in Exhibit G. In addition to any other provisions OHA may require, Contractor shall include in any permitted subcontract under this Contract provisions to ensure that OHA will receive the benefit of Subcontractor performance as if the Subcontractor were the Contractor with respect to Sections 1, 2, 3, 4, 13, 14, 17, 18 and 21 of this Exhibit D. OHA's consent to any subcontract shall not relieve Contractor of any of its duties or obligations under this Contract. In addition to the requirements in this section, Contractor shall comply with Exhibit B, Part 8, Section 14.

19. No Third Party Beneficiaries

OHA and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons that are greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

20. Amendments; Waiver; Consent

a. OHA may amend this Contract to the extent provided herein, or in any solicitation document from which this Contract arose, and to the extent permitted by applicable statutes and administrative rules. No amendment waiver, or other consent under this Contract shall bind either party unless it is in writing and signed by the party to be bound, and when required, the Department of Justice. Such amendment, waiver, or consent shall be effective only in the specific instance and for the specific purpose given. The failure of either party to enforce any provision of this Contract shall not constitute a waiver by that party of that or any other provisions.

b. OHA may provide Contractor with an amendment if OHA is required to amend this Contract due to changes in federal or State statute or regulations, or due to changes in Covered Services and CCO Payments under ORS 414.735, and if failure to amend this Contract to execute those changes in the time and manner proposed in the amendment may place OHA at risk of non-

compliance with federal or State statute or regulations or the requirements of the Legislature or Legislative Emergency Board. In addition, OHA may, at OHA's sole discretion, amend the Contract to address budgetary constraints, including those arising from changes in funding, appropriations, limitations, allotments, or other expenditure authority limitations provided in Section 6 of this Exhibit D. OHA may provide Contractor with an amendment if OHA's actuary recalculates Standard population CCO Payment rates under Exhibit C, Section 2. OHA will send to Contractor the necessary Contract amendment(s) no later than 15 days before the proposed effective date of the amendment; and 30 days for review of a rate sheet before the proposed effective date of the amendment of the CCO Payment rates.

c. Any changes in the CCO Payment rates under ORS 414.735 shall take effect on the date approved by the Legislative Assembly or the Legislative Emergency Board. Any changes required by federal or State law or regulation shall take effect not later than the effective date of the federal or State law or regulation.

21. Severability

If any term or provision of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Contract did not contain the particular term or provision held to be invalid.

22. Survival

Sections 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 21 and 22 of this Exhibit D shall survive Contract expiration or termination, as well as those provisions of this Contract that by their context are meant to survive. Contract expiration or termination shall not extinguish or prejudice OHA's right to enforce this Contract with respect to any default by Contractor that has not been cured.

23. Notices

a. Except as otherwise expressly provided in this Contract, any communications between the parties hereto or notices to be given hereunder shall be given in writing by personal delivery, facsimile, email or mailing the same, postage prepaid, to Contractor or OHA at the addresses or numbers set forth in this Contract, or to such other addresses or numbers as either party may indicate pursuant to this Contract. Any communication or notice so addressed and mailed by regular mail shall be deemed received and effective five days after the date of mailing. Any communication or notice delivered by facsimile or email shall be deemed received and effective on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours, or on the next Business Day, if transmission was outside normal business hours of the recipient. Any communication or notice given by personal delivery shall be effective when actually delivered to the addressee. Notwithstanding the foregoing, to be effective against OHA, any notice transmitted by facsimile must be confirmed by telephone notice to Office of Contracts and Procurement number listed below, any other number as set forth in the Contract, or any such telephone number OHA may provide by written notice to Contractor.

OHA: Office of Contracts & Procurement
DHS
250 Winter Street NE
Salem, Oregon 97301
Telephone: 503-945-5818
Facsimile: 503-378-4324

Contractor: See Contract Document, Part 4, Section B

Member: To the latest address provided for the Member on an address list, Enrollment or change of address form actually received by Contractor.

24. Construction

This Contract is the product of extensive negotiations between OHA and Contractor. The provisions of this Contract are to be interpreted and their legal effects determined as a whole. A court interpreting this Contract shall give a reasonable, lawful and effective meaning to this Contract to the extent possible. The rule of construction that ambiguities in a written agreement are to be construed against the party preparing or drafting the agreement shall not be applicable to the interpretation of this Contract.

25. Headings

The headings and captions to sections of this Contract have been inserted for identification and reference purposes only and shall not be used to construe the meaning or to interpret this Contract.

26. Merger Clause

This Contract constitutes the entire agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this Contract.

27. Counterparts

This Contract and any subsequent amendments may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Contract and any amendments so executed shall constitute an original.

28. Equal Access

Contractor shall provide equal access to Covered Services for both male and female Members under 18 years of age, including access to appropriate facilities, services and treatment, to achieve the policy in ORS 417.270.

29. Media Disclosure

Contractor shall not provide information to the media regarding a recipient of services under this Contract without first consulting with and receiving approval from the OHA case manager that referred the child or Family. Contractor shall make immediate contact with the OHA office when media contact occurs. The OHA office will assist the Contractor with an appropriate follow-up response for the media.

30. Mandatory Reporting

Contractor shall immediately report any evidence of child abuse, neglect or threat of harm to DHS Child Protective Services or law enforcement officials in full accordance with the mandatory Child Abuse Reporting law (ORS 419B.005 to 419B.045). If law enforcement is notified, the Contractor shall notify the referring caseworker within 24 hours. Contractor shall immediately contact the local DHS Child Protective Services office if questions arise whether an incident meets the definition of child abuse or neglect.

31. OHA Compliance Review

OHA is authorized to monitor compliance with the requirements in the Statement of Work. Methods of monitoring compliance may include review of documentation submitted by Contractor, Contract performance review, Grievances, on-site review of documentation or any other source of relevant information, including CCO and Subcontractor information and cooperation required under Exhibit B, Part 8 (Operations). Contractor agrees to cooperate to make records and facilities available for compliance review, consistent with Exhibit D, Section 13 of this Contract.

Compliance with performance and quality outcome measures is discussed in greater detail in Exhibit B, Part 8. Where specific processes for monitoring and compliance are specified in Exhibit B, Part 8, or other portions of the Statement of Work, those specific processes will be followed. Monitoring and compliance requirements in the Statement of Work shall be construed to be consistent with the terms and conditions in this Sections 32 through 35.

If compliance cannot be determined, or if OHA determines that Contractor is non-compliant with the requirements of the Contract, OHA may find Contractor has breached Contract requirements and may impose Sanctions under Exhibit D, Sections 32 through 35, of this Contract, and pursue other remedies available under this Contract.

32. Conditions that May Result in Sanctions

OHA may impose sanctions, as specified in Subsection 33 of this Exhibit, if it determines that Contractor has acted or failed to act as described in this Subsection 32 or any other provision of this Contract. OHA's determination may be based on findings from an onsite survey, Member or other complaints, financial status or any other source.

Conditions that may result in a Sanction under this section may include when Contractor acts or fails to act as follows:

a. Fails substantially to provide Medically Appropriate services that the Contractor is required to provide, under law or under its Contract with OHA, to a Member covered under this Contract;

b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;

c. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of Enrollment or refusal to reenroll a Member, except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage Enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;

d. Misrepresents or falsifies any information that it furnishes to CMS or to the State, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this Contract, encounter data or other information relating to care or services provided to a Member;

e. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;

f. Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210, and this Contract;

g. Fails to comply with the operational and financial reporting requirements specified in this Contract;

h. Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services under this Contract;

i. Fails to maintain an internal Quality Improvement program, or fraud and Abuse prevention program, or to provide timely reports and data required under Exhibit B, Part 1 through Part 9 and Exhibit L, of this Contract;

j. Failure to maintain an internal QA/PI program;

k. Fails to comply with Grievance and Appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, and record keeping and reporting requirements;

l. Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services required under this Contract;

m. Fails to follow accounting principles or accounting standards or cost principles required by federal or State laws, rule or regulation, or this Contract;

n. Fails to make timely Claims payment to Providers or fails to provide timely approval of authorization requests;

o. Fails to disclose required ownership information or fails to supply requested information to OHA on Subcontractors and suppliers of goods and services;

p. Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;

q. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;

r. Fails to comply with a term or condition of this Contract, whether by default or breach of this Contract. Imposition of a sanction for default or breach of this Contract does not limit OHA's other available remedies;

s. Violates of any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

t. Fails to submit accurate, complete and truthful pharmacy data in the time and manner required by Exhibit B, Part 8, Section 7; or

u. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

33. Range of Sanctions Available

Sanctions that may be imposed include but are not limited to the following sanctions. The use of one sanction by OHA does not preclude the imposition of any other sanction or combination of sanctions or any other remedy authorized under this Contract for the same deficiencies. OHA may:

a. Assess a Recovery Amount in the amounts authorized in 42 USC 1396u-2(e)(2);

b. Assess a Recovery Amount equal to one percent (1%) of Contractor's last monthly CCO Payment immediately prior to imposition of the sanction, to be deducted from Contractor's next monthly CCO Payment after imposition of sanction, except when a Recovery Amount has been assessed under Paragraph (1) of this subsection;

c. Grant Members the right to disenroll without cause (OHA may notify the affected Members of their right to disenroll);

d. Suspend all new Enrollment, including default Enrollment, or reduce the Enrollment level and/or the number of Contractor's current Members after the effective date of the sanction;

e. Suspend payment for Members enrolled after the effective date of the sanction until OHA is satisfied that the reasons for imposition of the sanction no longer exists and is not likely to recur;

f. Where financial solvency is involved, actions may include Increased reinsurance requirements; increased reserve requirements; market conduct constraints; and financial examinations

g. Require Contractor to develop and implement a plan that is acceptable to OHA for correcting the problem.

(1) At a minimum, the Corrective Action Plan must include:

(a) A written standard of conduct to be implemented by the Contractor that corrects the specific areas of non-compliance, how that standard of conduct will be established and maintained within Contractor's as well as Subcontractor's (as applicable) organization; and

(b) Designation of the person with authority within Contractor's organization charged with the responsibility of accomplishing and monitoring compliance.

(2) If Contractor has not submitted a Corrective Action Plan that is acceptable to OHA within the specified time period or does not implement or complete the Corrective Action within the specified time period, OHA will proceed with other sanctions or with termination of this Contract.

h. If OHA determines that there is continued egregious behavior that is described in Exhibit B of this Contract; or that there is substantial risk to Members' health; or that action is necessary to ensure the health of Members while improvements are made to remedy violations or until there is an orderly termination or reorganization by Contractor:

(1) OHA must require Contractor to implement temporary management mechanisms, such as employment of consultants or other individuals or entities approved by OHA for the purpose, at Contractor's expense;

(2) OHA must grant Members the right to disenroll without cause and notify Members of the right to disenroll without cause;

(3) OHA must not delay the imposition of temporary management mechanisms to provide for Administrative Review before imposing this sanction; and

(4) OHA must not terminate temporary management mechanisms until it determines that Contractor can ensure that the sanctioned behavior will not recur.

i. Deny payments under this Contract for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with 42 CFR 438.730; or

j. Any other sanctions reasonably designed to remedy and/or compel future compliance with this Contract.

34. Sanction Process

OHA will notify the Contractor in writing of its intent to impose a sanction. The notification shall explain the factual basis for the sanction, reference to the section(s) of this Contract or federal or State law or regulation that has been violated, explain the actions expected of Contractor, and state the Contractor's right to file a request for Administrative Review with the Director of OHA in writing within 30 days of the date of the sanction notice.

Notwithstanding the preceding provision of this Subsection c., in cases in which OHA determines that conditions could compromise a Member's health or safety or when OHA acts pursuant to Subsection b, Paragraph (7) of this section, OHA may provisionally impose the sanction before such Administrative Review opportunity is provided.

a. Contractor shall make Recovery Amount payments in full to OHA within 30 days of the date of the sanction notice, unless Contractor has made a timely request for Administrative Review pursuant to this Subsection c. above in which case Contractor may withhold payment of a disputed amount pending the issuance of the Administrative Review decision. Absent a timely request for Administrative Review, if Contractor fails to make payment within 30 days of the sanction notice, OHA will recoup the recovery payment from Contractor's future Capitation Payment(s) or as otherwise provided under this Contract, until the Recovery Amount payment is satisfied.

b. The Administrative Review process described in Subsections b, Paragraph (7) of this section and this Subsection c, will be conducted in the same manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that Administrative Review is the sole avenue for review of sanction decisions under this Exhibit D, Sections 32 through 35 of this Contract.

35. Notice to CMS of Contractor Sanction

OHA will give CMS' Regional Office written notice, no later than 30 days after Contractor has a sanction imposed or lifted by OHA for one of the violations listed in this Section 32, Subsection a through f, or q, in accordance with 42 CFR 438.724. OHA may, at OHA's discretion, give CMS' Regional Office written notice whenever Contractor has a sanction imposed or lifted by OHA for any breach or violation of this Contract requirement excluding those specifically noted above.

Exhibit E - Required Federal Terms and Conditions

Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, Contractor shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable to this Contract, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Contract, all references to federal and State laws are references to federal and State laws as they may be amended from time to time.

1. Miscellaneous Federal Provisions

Contractor shall comply and cause all Subcontractors to comply with all federal laws, regulations and executive orders applicable to this Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and cause all Subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to this Contract: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements , Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (j) all federal law governing operation of CMHPs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402.

2. Equal Employment Opportunity

If this Contract, including amendments, is for more than $10,000, then Contractor shall comply and cause all Subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. Clean Air, Clean Water, EPA Regulations

If this Contract, including amendments, exceeds $100,000 then Contractor shall comply and cause all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, DHHS and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and cause all Subcontractors to include in all contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

4. Energy Efficiency

Contractor shall comply and cause all Subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163).

5. Truth in Lobbying

The Contractor certifies, to the best of the Contractor's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

d. This certification is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31, of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

6. HIPAA Compliance

The parties acknowledge and agree that each of OHA and the Contractor is a “covered entity” for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA). OHA and Contractor shall comply with HIPAA to the extent that any Work or obligations of OHA arising under this Contract are covered by HIPAA. Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records required to comply with this Contract and with HIPAA. Contractor shall comply and cause all Subcontractors to comply with HIPAA and the following:

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information

relating to specific individuals may be exchanged between Contractor and OHA for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR 407-014-0000 et. seq., or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/Forms/Served/DE2090.pdf , or may be obtained from OHA.

b. HIPAA Information Security. Contractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of this Contract. Security incidents involving Member Information must be immediately reported to DHS' Privacy Officer.

c. Data Transactions Systems. Contractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS EDT Rules, OAR 410-001-0000 through 410-001-0200. In order for Contractor to exchange electronic data transactions with OHA in connection with Claims or encounter data, eligibility or Enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules.

d. Consultation and Testing. If Contractor reasonably believes that the Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the OHA HIPAA officer. Contractor or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.

7. Resource Conservation and Recovery

Contractor shall comply and cause all Subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

8. Audits

Contractor shall comply and, if applicable, cause a Subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations."

9. Debarment and Suspension

Contractor shall not permit any person or entity to be a Subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible

under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

10. Drug-Free Workplace

Contractor shall comply and cause all Subcontractors to comply with the following provisions to maintain a drug-free workplace: (i) Contractor certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Contractor's workplace or while providing services to Clients. Contractor's notice shall specify the actions that will be taken by Contractor against its employees for violation of such prohibitions; (ii) Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, Contractor's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations; (iii) Provide each employee to be engaged in the performance of services under this Contract a copy of the statement mentioned in Paragraph (i) above; (iv) Notify each employee in the statement required by Paragraph (i) above, that, as a condition of employment to provide services under this Contract, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction; (v) Notify OHA within 10 days after receiving notice under Paragraph (iv) above, from an employee or otherwise receiving actual notice of such conviction; (vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of Paragraphs (i) through (vi) above; (viii) Require any Subcontractor to comply with Paragraphs (i) through (vii) above; (ix) Neither Contractor, or any of Contractor's employees, officers, agents or Subcontractors may provide any service required under this Contract while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Contractor or Contractor's employee, officer, agent or Subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Contractor or Contractor's employee, officer, agent or Subcontractor's performance of essential job function or creates a direct threat to Clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities; and (x) Violation of any provision of this subsection may result in termination of this Contract.

11. Pro-Children Act

Contractor shall comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.).

12. Additional Medicaid and CHIP Requirements

Contractor shall comply with all applicable federal and State laws and regulations pertaining to the provision of OHP Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

a. Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such person or institution for providing OHP Services as the State or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2); and 42 CFR 457.950(a)(3).

b. Comply with all disclosure requirements of 42 CFR 1002.3(a); 42 CFR 455 Subpart (B); and 42 CFR 457.900(a)(2).

c. Maintain written notices and procedures respecting Advance Directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 Subpart I.

d. Certify when submitting any Claim for the provision of OHP Services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the Claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws.

e. Entities receiving $5 million or more annually (under this Contract and any other OHP contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and Abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 USC § 1396a(a)(68).

13. Agency-based Voter Registration

If applicable, Contractor shall comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an individual may apply for or receive an application for public assistance.

14. Clinical Laboratory Improvements

Contractor shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

15. Advance Directives

Contractor shall comply with 42 CFR Part 422.128 for maintaining written policies and procedures for Advance Directives. This includes compliance with 42 CFR 489, Subpart I "Advance Directives" and OAR 410-120-1380, which establishes, among other requirements the requirements for compliance with Section 4751 of the Omnibus Budget Reconciliation Act of 1991 (OBRA) and ORS 127.649, Patient Self-Determination Act. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members receiving medical care by Contractor. Contractor shall provide adult Members with written information on Advance Directive policies and include a description of Oregon law. The written information provided by Contractor must reflect changes in Oregon law as soon as possible, but no later than 90 days after the effective date of any change to Oregon law. Contractor must also provide written information to adult Members with respect to the following:

a. Their rights under Oregon law; and

b. Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

c. The Contractor must inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

16. Office of Minority, Women and Emerging Small Businesses

If Contractor lets any subcontracts, Contractor shall take affirmative steps to: include qualified small and minority and women's businesses on solicitation lists, assure that small and minority and women's businesses are solicited whenever they are potential sources, divide total requirements into smaller tasks or quantities when economically feasible so as to permit maximum small and minority and women's business participation, establish delivery schedules when requirements permit which will encourage participation by small and minority and women's businesses, and use the services and assistance of the Small Business Administration, the Office of Minority Business Enterprise of the Department of Commerce and the Community Services Administration as required.

17. Practitioner Incentive Plans (PIP)

Contractor may operate a Practitioner Incentive Plan only if no specific payment is made directly or indirectly under the plan to a Provider as inducement to reduce or limit Medically Appropriate Covered Services provided to a Member. Contractor shall comply with all requirements of Exhibit H, Practitioner Incentive Plan Regulation Guidance, to ensure compliance with Sections 4204 (a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern Practitioner Incentive Plans.

18. Risk HMO

If Contractor is a Risk HMO and is sanctioned by CMS under 42 CFR 438.730, payments provided for under this Contract will be denied for Members who enroll after the imposition of the sanction, as set forth under 42 CFR 438.726.

19. Conflict of Interest Safeguards

a. Contractor shall not recruit, promise future employment, or hire any DHS or OHA employee (or their relative or member of their household) who has participated personally and substantially in the procurement or administration of this Contract as a DHS or OHA employee.

b. Contractor shall not offer to any DHS or OHA employee (or any relative or member of their household) any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020(6) and OAR 199-005-0001 to 199-005-0035.

c. Contractor shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Contractor in connection with this Contract if that person participated personally and substantially in the procurement or administration of this Contract as a DHS or OHA employee.

d. If a former DHS or OHA employee authorized or had a significant role in this Contract, Contractor shall not hire such a person in a position having a direct, beneficial, financial interest in this Contract during the two year period following that person's termination from DHS or OHA.

e. Contractor shall develop appropriate policies and procedures to avoid actual or potential conflict of interest involving Members, DHS or OHA employees, and sub-contractors. These policies and procedures shall include safeguards:

(1) against the Contractor's disclosure of applications, bids, proposal information, or source selection information; and

(2) requiring the Contractor to:

(a) promptly report any contact with an applicant, bidder or offeror in writing to OHA; and

(b) reject the possibility of possible employment; or disqualify itself from further personal and substantial participation in the procurement if Contractor contacts or is contacted by a person who is an applicant, bidder or offeror in a procurement involving federal funds regarding possible employment for the Contractor.

f. The provisions of this section on Conflict of Interest are intended to be construed to assure the integrity of the procurement and administration of this Contract. For purposes of this Section:

(1) "Contract" includes any similar contract between Contractor and OHA for a previous term.

(2) Contractor shall apply the definitions in the State Public Ethics Law, ORS 244.020, for "actual conflict of interest", "potential conflict of interest", "relative" and "member of household".

(3) "Contractor" for purposes of this section includes all Contractor's affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common control with the Contractor; any officers, directors, partners, agents and employees of such person; and all others acting or claiming to act on their behalf or in concert with them.

(4) "Participates" means actions of a DHS or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the Contract.

(5) "Personally and substantially" has the meaning set forth in 5 CFR 2635.402(b)(4).

20. Non-Discrimination

a. Contractor shall comply with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules.

b. Contractor shall comply with and cause its subcontractors to comply with the integration mandate in 28 CFR 35.130(d), Title II of the Americans with Disabilities Act and its implementing regulations published in the Code of Federal Regulations.

21. OASIS

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Outcome and Assessment Information Set (OASIS) reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 64 FR 3764, 64 FR 3748, 64 FR 23846, and 64 FR 32984, and such subsequent regulations as CMS may issue in relation to the OASIS program.

22. Patient Rights Condition of Participation

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Patient Rights Condition of Participation (COP) that hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Contract, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

23. Federal Grant Requirements

The federal Medicaid rules establish that OHA is a recipient of federal financial assistance, and therefore is subject to federal grant requirements pursuant to 42 CFR 430.2(b). To the extent applicable to Contractor or to the extent OHA requires Contractor to supply information or comply with procedures to permit OHA to satisfy its obligations federal grant obligations or both, Contractor must comply with the following parts of 45 CFR:

a. Part 74, including Appendix A (uniform federal grant administration requirements);

b. Part 80 (nondiscrimination under Title VI of the Civil Rights Act);

c. Part 84 (nondiscrimination on the basis of handicap);

d. Part 91 (nondiscrimination on the basis of age);

e. Part 95 (Medicaid and CHIP federal grant administration requirements); and

f. Contractor shall not expend, and Contractor shall include a provision in any Subcontract that its Subcontractor shall not expend, any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.

Exhibit F – Insurance Requirements

Required Insurance: Contractor shall obtain at Contractor's expense the insurance specified in this Exhibit F, prior to performing under this Contract, and shall maintain it in full force and at its own expense throughout the duration of this Contract. Contractor shall obtain the following insurance from insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are reasonably acceptable to OHA.

1. **Workers' Compensation:** All employers, including Contractor, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017, and shall provide worker's compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Contractor shall require and ensure that each of its Subcontractors complies with these requirements.

   Professional Liability: Covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract. This insurance shall include claims of negligent provider selection, direct corporate professional liability, wrongful denial of treatment, and breach of privacy. Contractor shall provide proof of insurance with not less than the following limits:

   From Contract effective date through June 30, 2013

   Per occurrence limit for any single Claimant of not less than $1,800,000, and
   Per occurrence limit for multiple Claimants of not less than $3,600,000.

2. **Commercial General Liability:** Covers bodily injury, death and property damage in a form and with coverages that are satisfactory to the State. This insurance shall include personal injury liability, products and completed operations. Coverage shall be written on an occurrence basis. Contractor shall provide proof of insurance with not less than the following limits:

   Bodily Injury/Death

   From Contract effective date through June 30, 2013

   A combined single limit per occurrence of not less than $1,800,000, and
   An aggregate limit for all claims of not less than $3,600,000.

   AND

   Property Damage:

   From Contract effective date through June 30, 2013

   A combined single limit per occurrence of not less than $104,400, and
   An aggregate limit for all claims of not less than $506,900.

3. **Automobile Liability:** Covers all owned, non-owned, or hired vehicles, this coverage may be written in combination with the Commercial General Liability Insurance (with separate limits for "Commercial General Liability" and "Automobile Liability"). Contractor shall provide proof of insurance with no less than the following limits:

Bodily Injury/Death

From Contract effective date through June 30, 2013

A combined single limit per occurrence of not less than $1,800,000, and
An aggregate limit for all claims of not less than $3,600,000.

AND

Property Damage:

From Contract effective date 1, 2012 through June 30, 2013

A combined single limit per occurrence of not less than $104,400, and
An aggregate limit for all claims of not less than $506,900.

4. **Additional Insured:** The Commercial General Liability insurance and Automobile Liability insurance required under this Contract shall include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to Contractor's activities to be performed under this Contract. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

5. **Notice of Cancellation or Change:** Contractor shall assure that no cancellation, material change, potential exhaustion of aggregate limits or non–renewal of insurance coverage(s) occurs without 60 days prior written notice from Contractor or its insurer(s) to OHA. Any failure to comply with this clause constitutes a material breach of Contract and is grounds for immediate termination of this Contract by OHA.

6. **Proof of Insurance:** Contractor shall provide to OHA information requested in Part VII "Contractor Data and Certification" of the Contract Document, for all required insurance before delivering any goods and performing any services required under this Contract. Contractor shall pay for all deductibles, self insured retentions, and self insurance, if any.

7. **"Tail" Coverage:** If any of the required liability insurance is on a "claims made" basis, Contractor shall either maintain either "tail" coverage or continuous "claims made" liability coverage, provided the effective date of the continuous "claims made" coverage is on or before the effective date of this Contract, for a minimum of 24 months following the later of (i) Contractor's completion and OHA's acceptance of all Services required under this Contract, or, (ii) The expiration of all warranty periods provided under this Contract. Notwithstanding the foregoing 24-month requirement, if Contractor elects to maintain "tail" coverage and if the maximum time period "tail" coverage reasonably available in the marketplace is less than the 24-month period described above, then Contractor shall maintain "tail" coverage for the maximum time period that "tail" coverage is reasonably available in the marketplace for the coverage required under this Contract. Contractor shall provide to OHA, upon OHA's request, certification of the coverage required under this Section 8.

8. **Self-insurance:** Contractor may fulfill one or more of its insurance obligations herein through a program of self insurance, provided that Contractor's self insurance program complies with all applicable laws, provides coverage equivalent in both type and level to that required in this Exhibit F, and is reasonably acceptable to OHA. Notwithstanding Section 7 of this Exhibit F, Contractor shall furnish an acceptable insurance certificate to OHA for any insurance coverage required by this Contract that is fulfilled through self-insurance.

Exhibit G – Delivery System Network (DSN) Provider and Hospital Adequacy Reporting Requirements

1. DSN Provider Reports

a. Contractor shall submit DSN Provider reports to OHA upon effective date of this Contract and upon any significant change of Contractor's services, benefits, services area, or payments.

b. 42 CFR 438.206 "Availability of Services" and 42 CFR 438.207 "Assurances of Adequate Capacity and Services" require Contractor to ensure to OHA, with supporting documentation, that all services covered under this Contract are available and accessible to Members and that the Contractor demonstrates adequate Provider capacity.

c. Contractor shall provide the following information of how Contractor requires and monitors adequate Provider capacity. If any of the activities are subcontracted, describe how Contractor provides oversight and monitoring of the activities as well.

(1)

(a) How does Contractor or delegate(s) maintain a network of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?

(b) How does Contractor or delegate(s) monitor the network of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?

(2) If the network is unable to provide necessary services, covered under this Contract, to a particular Member, how does Contractor or delegate(s) provide adequate and timely services out of network for a Member, for as long as the Contractor or delegate(s) is unable to provide them within the network?

(3)

(a) How does Contractor or delegate(s) require Providers to meet OHA standards for timely access to routine, urgent and emergent care and services, taking into account the urgency of the need for services?

(b) How does Contractor or delegate(s) monitor compliance by Providers of timely access to care and services?

(c) How does Contractor or delegate(s) monitor availability of services when medically necessary routine, urgent and emergent services?

d. What Corrective Actions has Contractor or delegate(s) taken if there was a failure to comply with any provision or timeliness of services during the prior year? If, any, what is the current status of the Corrective Action and compliance?

e. In the current year, what is Contactor or delegate(s) doing to provide delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds?

f. What does Contractor do to monitor subcontracted activities related to Provider capacity? Be specific to each activity subcontracted.

g. Contractor shall submit a list of participating QMHP Practitioners and participating facilities to include the following elements:

Practitioner List

Name
Agency/Location
Telephone Number
Non-English Language Spoken

Facility List

Name of Facility
Psychiatric Day Treatment Facility
Psychiatric Residential Treatment Services Facility

h. DSN Provider Report:

Contractor shall submit the Provider Capacity Report to OHA in the electronic format of Microsoft Excel. The field types and sizes are required and may be submitted in an alternate format if Contractor obtains prior approval from OHA by contacting Contractor's CCO Coordinator or designee.

Required Data Elements

Practitioner List

Name
Type of Provider
Address
Telephone Number
Non-English Language Spoken
Last Date Credentialed

Facility List

Name of Facility
Type of Facility
Address
Telephone Number
Last Date Credentialed

i. Community Social and Support Service Organizations Involvement Report:

The following table details Contractor's involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which Contractor has involvement with.

Name of publicly funded program	Type of public program (i.e. county mental health dept.)	County in which program provides services	Description of the services provided in relation to Contractor's services	What has been the involvement of the public program in Contractor's operations (on the board, on Quality Assurance Committee, specify if subcontract, etc.)?

j. Provider Type and Provider Specialty Code Listing:

Contractor shall utilize 1) the Provider/ Type code table and 2) Provider specialty code table to specify the required information on Contractor's Provider Capacity Report file as outlined in Section 3, Required Data Elements, line number 9 of this Exhibit. Both forms can be obtained from Contractor's CCOC.

2. Hospital Network Adequacy

a. Contractor shall submit to its OHA by March 31, 2013, the Hospital Adequacy Report found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx. This Hospital Adequacy Report is an annual report of admissions and paid amounts from July 1 of every year to June 30 of every year, that details hospital admissions at Contracted Hospitals and hospital admissions at Non-Contracted Hospitals. The Hospital Adequacy Report will also include the Contractor's total outpatient costs at Contracted Hospitals and the Contractor's total outpatient costs at Non-Contracted Hospitals. OHA will review and analyze non-contracted claims by Contractor annually to determine if all hospital services are adequately represented.

b. Contractor and hospitals are expected to contract for an adequate hospital network for a full range of services reasonably expected to meet the needs of the Contractor's number and location of Members.

Definitions:

Contracted Hospital - in this Exhibit G means a hospital that is a Subcontractor.

Non-Contracted Hospital – in this Exhibit G means a hospital that is not a Subcontractor.

The following benchmarks will be monitored and evaluated to assess the adequacy of a hospital network:

a. A minimum of 90% of Contractor's total inpatient admissions (excluding all outpatient services) shall be provided in hospitals under contract with the Contractor.

b. A minimum of 90% of Contractor's total dollars paid for all outpatient services (excluding amounts paid for inpatient admissions) shall be provided in hospitals under contract with the Contractor.

In those instances where the percentage of Non-Contracted Hospital services are below the benchmarks or the OHA review of the Contractor's annual report of hospital admissions by DRG indicates Contractor's hospital network is not adequate, OHA shall determine if the Contractor and hospital(s) have both made a good faith effort to contract with each other.

The determination of good faith shall consider the following:

a. The amount of time the Contractor has been actively trying to negotiate a contractual arrangement with the hospital(s) for the services involved;

b. The payment rates and methodology the Contractor has offered to the hospital(s);

c. The payment rates and methodology the hospital has offered to the Contractor;

d. Other hospital cost associated with non-financial contractual terms the Contractor has proposed including prior-authorization and other utilization management policies and practices;

e. The Contractor's track record with respect to claims payment timeliness, overturned claims, denials, and hospital complaints;

f. The Contractor's solvency status; and

g. The hospital(s)' reasons for not contracting with the Contractor.

c. If OHA determines that the Contractor has made a good faith effort to contract with the hospital, OHA shall modify the benchmark calculation, if necessary, for the Contractor to exclude the hospital so the Contractor is not penalized for a hospital's failure to contract in good faith with the Contractor.

d. If OHA determines that the Contractor did not make a good faith effort, to negotiate and enter into reasonable contracts, OHA may invoke the following remedies (until such time that the Contractor achieves the benchmarks and/or provides documentation to OHA that is has an adequate hospital panel):

(1) Monthly reporting;

(2) Partial withholding of CCO Payments (to be returned retroactively to the Contractor upon achieving compliance or termination/non-renewal of the contract); and finally,

(3) Termination or non-renewal of this Contract.

Exhibit H – Physician Incentive Plan Regulation Guidance

1. Background/Authority:

This Contract requires that Contractor complies with the requirements set forth in 42 CFR 422.208 and 422.210 by disclosing information about Practitioner Incentive Plans (PIP) to OHA. If Contractor utilizes compensation arrangements placing Physicians or Physician Groups at Substantial Financial Risk (as defined in this Exhibit) Contractor must also assure provision of adequate PIP Stop-loss Protection and conduct beneficiary surveys.

These Contract requirements implement federal law and regulations to protect Members against improper clinical decisions made under the influence of strong financial incentives. Therefore, it is the financial arrangement under which the Physician is operating that is of interest and potential concern. Consequently, Contractors must report on the "bottom tier" - that is, the arrangement under which the participating Physician is operating. The reporting requirement is imposed on Contractors because that is the entity or Physician Group with which OHA has a contractual relationship and the entity, which is ultimately responsible, under the statute, for making sure that adequate safeguards are in place.

A Physician Incentive Plan (PIP) is defined as "any compensation to pay a Physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to any Member". The compensation arrangements negotiated between Subcontractors of an MCO (e.g., Physician-hospital organizations, IPAs) and a Physician or group are of particular importance, given that the compensation arrangements with which a Physician is most familiar will have the greatest potential to affect the Physician's referral behavior. For this reason, all Subcontracting tiers of the Contractor's arrangements are subject to the regulation and must be disclosed to OHA.

Note that PIP rules differentiate between Physician Groups and Intermediate Entities. Examples of Intermediate Entities include Individual Practice Associations (IPAs) that contract with one or more Physician Groups, as well as Physician-hospital organizations. IPAs that contract only with individual Physicians and not with Physician Groups are considered Physician Groups under this rule.

2. Glossary of Terms:

As used in this Exhibit H, these terms have the following meaning wherever the term is used, unless expressly defined otherwise in this Contract.

Bonus means a payment a physician or entity receives beyond any salary, fee-for-service payments, Capitation or returned withhold. Bonuses and other compensation that are not based on referral levels (such as Bonuses based solely on quality of care, patient satisfaction or physician participation on a committee) are not considered in the calculation of Substantial Financial Risk.

Capitation means a set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include a physician's own services, Referral Services or all medical services.

Panel Size means the number of patients served by a physician or Physician Group. If the panel is greater than 25,000 patients, then the Physician Group is not considered to be at Substantial Financial Risk because the risk is spread over the large number of patients. PIP Stop-loss Protection and Beneficiary Surveys would not be required.

Physician Group means a partnership, association, Corporation, Individual Practice Association (IPA), or other group that distributes income from the practice among members. An IPA is a Physician Group only if it is composed of individual physicians and has no subcontracts with other Physician Groups.

Intermediate Entities are entities, which contract between Contractor and one of its Subcontractors and a physician or Physician Group, other than Physician Groups themselves. An IPA is considered an Intermediate Entity if it contracts with one or more Physician Groups in addition to contracting with individual physicians.

Practitioner Incentive Plan (PIP) means any compensation arrangement at any contracting level between Contractor and a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to Members. Contractor must report on Practitioner Incentive Plans between the Contractor itself and individual physicians and groups and also between groups or Intermediate contracting Entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups.

PIP Stop-loss Protection refers to insurance required to protect Physicians or Physician Groups to whom Substantial Financial Risk has been transferred.

Potential Payments means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of Referral Services were low enough. These payments include amounts paid for services furnished or referred by the physician/group, plus amounts paid for administrative costs. The only payments not included in Potential Payments are Bonuses or other compensation not based on referrals (e.g., bonuses based on patient satisfaction or other quality of care factors).

Referral Services means any specialty, Inpatient, Outpatient or laboratory services that are ordered or arranged, but not furnished directly. Situations may arise where services not normally considered Referral Services will need to be considered Referral Services for purposes of determining if a physician/group is at Substantial Financial Risk. For instance, Contractor may require a physician/group to authorize "retroactive" referrals for emergency care received outside the Contractor's network. In so far as the physician/group can experience an increase in Bonus (if emergency referrals are low) or a reduction in capitation/increase in withhold (if emergency referrals are high), then these Emergency Services are considered Referral Services and need to be included in the calculation of Substantial Financial Risk.
Also, if a Physician Group contracts with an individual physician or another group to provide services, which the initial group cannot provide itself, any services referred to the contracted physician/group should be considered Referral Services.

Substantial Financial Risk (SFR) means an incentive arrangement that places the physician or Physician Group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of Referral Services. The risk threshold is 25%. Calculation of Substantial Financial Risk shall be determined pursuant to Section 3 of this Exhibit.

Withhold means a percentage of payments or set dollar amounts that are deducted from a service fee, capitation or salary payment, and that may or may not be returned, depending on specific predetermined factors.

3. Reporting to OHA

In order to determine compliance with 42 CFR 422.208-422.210, Contractor shall report to OHA the following information for each medical group and physician providing health services to the OHA Members:

-Whether any risk is transferred to the Provider
-Whether risk is transferred to the Provider for Referral Services
-What method is used to transfer risk
-What percent of the total Potential Payment to the Provider is at risk for referrals
-What is the number of patients included in the same risk arrangement if the number of patients is 25,000 or fewer, what is the type and amount of PIP Stop-loss Protection insurance
-Whether Contractor's Physician Incentive Plan places physicians or Physician Groups at "Substantial Financial Risk" as determined in Section 4 of this Exhibit M.
-If SFR is established:

a. the amount of PIP Stop-loss Protection required; and

b. the means for complying with survey requirements

Contractor shall file the CMS PIP Disclosure Form (OMB No. 0938-0700) with OHA.

4. Calculation and Determination:

Contractor shall determine the amount of referral risk by using the following formula:

Amount at risk for Referral Services
Referral Risk = Maximum Potential Payments

The amount at risk for Referral Services is the difference between the maximum potential referral payments and the minimum potential referral payments. Bonuses unrelated to utilization (e.g., quality bonuses such as those related to member satisfaction or open physician panels) should not be counted towards referral payments. Maximum Potential Payments is defined as the maximum anticipated total payments that the physician/group could receive. If there is no specific dollar or percentage amount noted in the incentive arrangement, then the PIP should be considered as potentially putting 100% of the Potential Payments at risk for Referral Services.

The SFR threshold is set at 25% of "Potential Payments" for Covered Services, regardless of the frequency of assessment (i.e. collection) or distribution of payments. SFR is present when the 25% threshold is exceeded. However, if the pool of patients that are included in the risk arrangement exceeds 25,000, the arrangement is not considered to be at SFR because the risk is spread over so many lives. See pooling rules below.

The following incentive arrangements should be considered as SFR:

a. Withholds greater than 25 percent of Potential Payments.

b. Withholds less than 25 percent of Potential Payments if the physician or Physician Group is potentially liable for amounts exceeding 25 percent of Potential Payments.

c. Bonuses that are greater than 33 percent of Potential Payments minus the Bonus.

d. Withholds plus Bonuses if the Withholds plus Bonuses equal more than 25 percent of Potential Payments. The threshold Bonus percentage for a particular Withhold percentage may be calculated using the formula: Withhold % = -0.75 (Bonus %)+25%.

e. Capitation, arrangements, if the difference between the maximum Potential Payments and the minimum Potential Payments is more than 25 percent of the maximum Potential Payments; or the maximum and minimum Potential Payments are not clearly explained in the physician's or Physician Group's contract.

f. Any other incentive arrangements that have the potential to hold a physician or Physician Group liable for more than 25 percent of Potential Payments.

5. If Contractor's Practitioner Incentive Plan places physicians or Physician Groups at SFR, Contractors shall:

- Establish and maintain PIP Stop-loss Protection, as required in this Section 4, Subsection a, and
- Conduct survey as required in Section 5 of this Exhibit.

a. PIP Stop Loss Protection

Stop-loss Protection must be in place to protect physicians and/or Physician Groups to whom SFR has been transferred. Either aggregate or per patient stop-loss may be acquired. Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and which provides reimbursement after the expected total cost exceeds a pre-determined level. Individual insurance is where a specific Provider excess loss accumulates based on per member per year Claims.

The rule specifies that if aggregate stop-loss is provided, it must cover 90% of the cost of Referral Services that exceed 25% of Potential Payments. Physicians and groups can be liable for only 10%. If per patient PIP Stop-loss Protection is acquired, it must be determined based on the physician or Physician Group's patient Panel Size (calculated according to Subsection b., of this Exhibit) and cover 90% of the referral costs which exceed the following per patient limits:

Panel Size	Combined Institutional Professional Deductible	Institutional Deductible	Professional Deductible
1-1000	$6,000*	$10,000*	$3,000*
1,001 - 5000	$30,000	$40,000	$10,000
5,001 - 8,000	$40,000	$60,000	$15,000
8,001 - 10,000	$75,000	$100,000	$20,000
10,001 - 25,000	$150,000	$200,000	$25,000
> 25,000	none	none	none

*The asterisks in this table indicate that, in these situations, PIP Stop-loss insurance would be impractical. Not only would the premiums be prohibitively expensive, but the protections for patients would likely not be adequate for panels of fewer than 500 patients. Contractors and Physician Groups clearly should not be putting physicians at financial risk for Panel Sizes this small. It is OHA's understanding that doing so is not common. For completeness, however, the table does show what the limits would be in these circumstances.

The institutional and professional stop-loss limits above represent the actuarial equivalents of the combined institutional and professional deductible. The Physician Group or Contractor may choose to purchase whatever type is best suited to cover the referral risk in the incentive arrangement.

b. Pooling Criteria

To determine the Patient Panel Size in the above chart, Contractor may pool according to the specific criteria below. If Contractor meets all five criteria required for the pooling of risk, Contractor is allowed to pool that risk in order to determine the amount of stop-loss required by the regulation:

(1) Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group;

(2) The physician or group is at risk for Referral Services with respect to each of the categories of patients being pooled;

(3) The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by Contractor or by Medicaid, Medicare, or commercial); and

(5) The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

c. Contractor shall establish a procedure under which their Subcontractors are required to submit stop-loss documentation. Contractors shall collect Stop-loss information from each Subcontractor and shall retain this information for a recommended three years.

6. Surveys:

Contractor shall conduct a customer survey of both Members and disenrollees if any physician or Physician Groups in the Contractor's network are placed at Substantial Financial Risk for Referral Services, as defined by the Physician Incentive Regulations. If a survey is required it must be conducted in accordance with Section 7, of this Exhibit M.

7. Disclosure to Members:

At Member's request, Contractor must provide information indicating whether it or any of its contractors or Subcontractors use a PIP that may affect the use of Referral Services, the type of incentive arrangement(s) used, and whether PIP Stop-loss Protection is provided. If Contractor is required to conduct a survey, it must also provide Members with a summary of survey results.

8. Monitoring:

a. Contractor shall file the CMS PIP Disclosure Form (OMB No. 0938-0700), with OHA according to the provisions of Exhibit B, Part IV, Section 1 Subsection e.

b. CMS PIP Disclosure Form (OMB No. 0938-0700), is subject to review by OHA and subject to correction/clarification.

Exhibit I – Grievance System

Contractor shall establish internal Grievance procedures under which Members, or Providers acting on their behalf, may challenge any Action. Contractor shall maintain its Grievance System in accordance with this exhibit, OAR 410-141-3260 through 410-141-3266, and 42 CFR 438.400 through 438.424.

1. Grievance System

Contractor shall have a system in place for Members that includes a Grievance process, an Appeal process and access to a Contested Case Hearing.

a. Filing Requirements

(1) A Member or Representative may file a Grievance, a Contractor level Appeal and may request a Contested Case Hearing;

(2) A Provider acting on behalf of the Member and with the Member's written consent, may file a Grievance, file an Appeal or request a Contested Case Hearing.

b. Timing

Within 45 days from the date on the Notice of Action (NOA):

(1) The Member or Provider may file an Appeal; and

(2) The Member or Provider acting on behalf of the Member, with written consent may request a Contested Case Hearing.

c. Procedures

(1) The Member may file a Grievance either orally or in writing; and

(2) The Member or Provider may file an Appeal either orally or in writing, and unless an expedited resolution is requested, must follow an oral filing with a written and signed Appeal.

2. Notice of Action

When Contractor intends to take any Action the Contractor shall mail a written NOA to the Member.

a. Contractor shall only use OHA approved NOA format. The NOA form shall meet the language and format requirements in Exhibit B, Part 3, Section 3 and include at a minimum the following information:

(1) Date of the notice;

(2) Contractor name, address and phone number;

(3) Provider name;

(4) Member's name and ID number;

(5) Date of Service or item requested or provided;

(6) Who requested or provided the item or service;

(7) Effective date of the Action;

(8) The Action the Contractor has taken or intends to take;

(9) Reason(s) for the Action, that clearly explains the actual reason for the denial, including, but not limited to, the following reasons:

(a) Treatment is not a Covered Service;

(b) The item requires prior authorization and it was not prior authorized;

(c) The service is not Medically Appropriate;

(d) The service or item was received in an emergency care setting and does not qualify as an Emergency Service;

(e) The person was not a Member at the time of the service or is not a Member at the time of a requested service; or

(f) The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior authorization would be required under the OHP Rules).

(10) A reference to the specific sections of the statutes and administrative rules involved for each reason identified in the NOA;

(11) The Member's or Provider's right to file an Appeal, and the procedures to exercise that right;

(12) The Member's right to request a Contested Case Hearing, and the procedures to exercise that right,

(13) The circumstances under which an expedited resolution is available and how to request it;

(14) The Member's rights to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of the services.

b. Contractor shall, for every NOA, meet the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Covered Services:

(a) The NOA shall be mailed at least 10 calendar days before the date of Action, except as permitted under Items (b) or (c) below.

(b) The NOA shall be mailed not later than the date of Action if:

(i) Contractor has factual information confirming the death of the Member;

(ii) Contractor receives a clear, written statement signed by the Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(iii) The Member has been admitted to an institution where he or she is ineligible for Covered Services from the Contractor;

(iv) The Member's whereabouts are unknown and the Contractor receives a notice from the post office indicating no forwarding address;

(v) The Contractor establishes the fact that another state, territory, or commonwealth has accepted the Member for Medicaid services in Appeal;

(vi) There is a change in the level of medical care that is prescribed by the Member's Provider;

(vii) There is an adverse determination made with regard to the preadmission screening requirements for LTPC admissions; or

(viii) The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or a Member has not resided in the LTPC for 30 days (applies only to adverse Actions for LTPC transfers).

(c) The NOA shall be mailed five calendar days before the date of the Action for Actions taken because of probable fraud on part of the Member. The Contractor shall have facts indicating that an Action should be taken because of probable fraud and whenever possible, these facts should be verified through secondary sources.

(2) For denial of payment, the NOA shall be mailed at the time of any Action that affects the Claim;

(3) For prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested:

(a) The NOA shall be mailed as expeditiously as the Member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(i) The Contractor may have an extension of up to 14 additional calendar days if the Member or the Provider requests the extension; or if the Contractor justifies (to OHA upon request) a need for additional information and how the extension is in the Member's interest;

(ii) If the Contractor extends the timeframe, in accordance with Item (i) above, it shall give the Member written notice of the reason for the

decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

(iii) The Contractor shall issue and carry out its prior authorization determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

(4) For prior authorization decisions not reached within the appropriate timeframes (which constitutes a denial and is thus an adverse Action), the NOA shall be mailed on the date that the timeframes expire;

3. Handling of Grievances and Appeals

Contractor shall meet all of the following requirements when handling Grievances and Appeal:

a. General Requirements

(1) Give Members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing certified and qualified interpreter services and toll-free numbers that have adequate TTY/TTD and certified and qualified interpreter capability;

(2) Acknowledge receipt of each Grievance and Appeal;

(3) Ensure that the individuals who make decisions on Grievances and Appeals are individuals:

(a) Who were not involved in any previous level of review or decisions-making; and

(b) Who, if deciding any of the following, are Health Care Professionalss who have the appropriate clinical expertise, as determined by OHA, in treating the Member's condition or disease:

(i) An Appeal of a denial that is based on lack of medical necessity,

(ii) A Grievance regarding denial of expedited resolution of an Appeal, and

(iii) A Grievance or Appeal that involves clinical issues.

b. Special Requirements for Appeals

The process for Appeals shall:

(1) Provide that oral inquiries seeking to Appeal an Action are treated as Appeals, in order to establish the earliest possible filing date, and must be confirmed in writing, unless the Member or the Provider requests an expedited resolution.

(2) Provide the Member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Member of the limited time available for this in the case of expedited resolution.

(3) Provide the Member and Representative opportunity, before and during the Appeals process, to examine the Member's case file, including medical records, and any other documents and records considered during the Appeal process.

(4) Provide the Member:

(a) The toll-free numbers that the Member can use to file a grievance or appeal by phone;

(b) The availability of assistance in the filing process;

(c) The rules that govern representation at the hearing;

(d) The right to have an Attorney or representative present at the hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711;

(5) Include as parties to the Appeal:

(a) The Member and the Representative,

(b) A Provider acting on behalf of a Member, with written consent from the Member;

(c) Contractor; and

(d) The legal representative of a deceased Member's estate.

c. Resolution and Notification for Grievances and Appeals

(1) Basic Rule

Contractor shall resolve each Grievance and Appeal, and provide notice, as expeditiously as the Member's health condition requires and within the timeframes in this section.

(2) Standard Resolution for Grievances

Notify the Member, within 5 working days from the date of the Contractor's receipt of the Grievance, of one of the following:

(a) A decision on the Grievance has been made and what that decisions is; or

(b) That there will be a delay in the Contractor's decision, of up to 30 calendar days. The written notice shall specify why the additional time is necessary.

(3) Notice of Resolution of Grievance

(a) If an oral Grievance was received an oral decision shall be provided.

(b) If a written Grievance was received, a written decision shall be provided.

(c) Either way the decision is relayed to the Member the decision shall address each aspect of the Member's Grievance and explain the reason for the Contractor's decision.

(d) Include in each notice of resolution to the Member, that is not in favor of the Member, that they may present the Grievance to DHS' Governor's Advocacy Office (GAO) at 503-945-6904 or toll free at 800-442-5238 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.

(e) Cooperate with the investigation and resolution of the Grievance by the GAO or OHA's Ombudsman, including providing all requested records.

(4) Standard Resolution for Appeals

All Appeals must be received no later than 45 calendar days from the date on the NOA.

(a) Resolve each Appeal as expeditiously as the Member's health condition requires and within the following time frames:

(i) No later than 16 calendar days from the day the Contractor receives the Appeal. This timeframe may be extended as follows:

(A) The Contractor may extend the timeframes by up to 14 calendar days if:

(I) The Member requests the extension; or

(II) The Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the Member's interest.

(B) If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member a written notice of the reason for the delay.

(5) Expedited Resolution for Appeals

The Member or Provider may file an expedited Appeal either orally or writing. No additional Member follow-up is required.

(a) For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited decision and provide notice as expeditiously as the

Member's health condition requires and no later than three working days after receipt of the request for service.

(b) Resolve each expedited Appeal request within three days from the date that the Contractor received the request for an expedited Appeal.

(c) The Contractor may extend the timeframes by up to 14 calendar days if:

(i) The Member requests the extension; or

(ii) The Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the Member's interest.

(d) If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member a written notice of the reason for the delay.

(e) If the Contractor provides an expedited Appeal, but denies the services or items requested in the expedited Appeal, the Contractor shall:

(i) Transfer the Appeal to the time frame for standard resolution in accordance with Section 3.a., above; and

(ii) Make reasonable efforts to give the Member prompt oral notice of the denial, and follow-up within two calendar days with a written notice.

The written notice must state the right of a Member, who believes that taking the time for a standard resolution of an Appeal and Contested Case Hearing could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, to request an expedited Contested Case Hearing.

(iii) Transmit the denial decision to OHA for review as an expedited Contested Case Hearing.

(iv) Submit all relevant documentation to OHA within two working days following the Member's expedited Contested Case Hearing request for a decision as to the necessity of an expedited Contested Case Hearing.

(f) Contractor shall ensure that punitive action is neither taken against a Provider who requests and expedited resolution or supports a Member's Appeal.

(6) Notice of Resolution of Appeals

All notice of resolution of an Appeal shall be in writing. For notice of an expedited resolution, Contractor shall make reasonable effort to provide oral notice.

(a) Content of Notice of Resolution of Appeal

The written notice of resolution of an Appeal shall include the following:

(i) The results of the resolution process and the date it was completed;

(ii) For Appeals not resolved wholly in favor of the Member:

(A) The right to request a Contested Case Hearing and how to do so, which in includes sending the Notice of Hearing Rights (DMAP 3030) and the Hearing Request Form (MSC 0443);

(B) The right to continue to receive benefits pending a Contested Care Hearing;

(C) The right to receive information stating how to request the continuation of benefits, and

(D) The right to receive information explaining how if the Contractor's action is upheld in a Contested Case Hearing, the Member may be liable for the cost of any continued benefits.

4. Contested Case Hearing Request

a. All Contested Case Hearing requests must be filed using a MSC 0443, with Contractor or OHA no later than 45 days from the date of the notice of Appeal resolution.

b. Upon receipt of a MSC 0443, from Member, Contractor shall immediately transmit the request to OHA and review the request as an Appeal as described in this exhibit.

c. Include as parties to the Contested Case Hearing:

(1) The Member and the Representative,

(2) Contractor; and

(3) The legal representative of a deceased Member's estate.

5. Continuation of Benefits While the Contractor Appeal and Contested Case Hearing is Pending:

As used in this section, "timely" filing means filing on or before the later of the following:

- Within 10 calendar days after the Contractor mails the Notice of Action; or
- The intended effective date of the Contractor's proposed Action.

a. The Contractor shall continue the Member's benefits if:

(1) The Member or Member's Representative files the Appeal or Administrative Hearing request timely;

(2) The Appeal or Administrative Hearing request involves the termination, suspension, or reduction of a previously authorized course of Treatment;

(3) The Services were ordered by an authorized Provider;

(4) The original period covered by the original authorization has not expired; and

(5) The Member requests extension of benefits.

a. Duration of Continued Benefits

(1) Continuation of Benefits Pending Contested Case Hearing:

If, at the Member's request, the Contractor continues or reinstates the Member's benefits while the Appeal is pending pursuant to 42 CFR 438.420(c) the benefits must be continued until one of the following occurs:

(a) The Member withdraws the Appeal; or

(b) The Member does not request a Contested Case Hearing within 10 days from when the Contractor mails an adverse decision; or

(c) A Contested Case Hearing decision adverse to the Member is made; or

(d) Until OHA issues an Appeal decision adverse to the Member; or

(e) The authorization expires or authorization service limits are met.

b. Member Responsibilities for Services Furnished While the Appeal is Pending:

If the final resolution of the Appeal is adverse to the Member, that is, upholds the Contractor's Action, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal was pending.

6. Implementation of Reversed Appeal Resolution

a. Services Not Furnished While an Appeal is Pending

If the Contractor or Contested Case Hearing reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide, the disputed services promptly, and as expeditiously as the Member's health condition requires.

b. Services Furnished While an Appeal is Pending

If the Contractor or Contested Case Hearing reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor or OHA will pay for the services.

7. Final Order

A final order should be issued or the case otherwise resolved by OHA within 90 calendar days from the earlier of the following: the date the Member filed the Appeal request with the Contractor or the date the Member filed the Contested Case Hearing request. The final order is the final decision of OHA.

8. Documentation and Quality Improvement

a. Contractor's shall document all Grievances and Appeals using the Grievance Log Sheet found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx and submit to OHA 60 days following the end of each calendar quarter. Contractor shall monitor the Grievance Log Sheets on a monthly basis for completeness and accuracy.

b. Contractor shall maintain a record, in a central location for each Grievance and Appeal included in the Grievance Log Sheet. The record shall include, at a minimum:

(1) Notice of Action;

(2) If filed in writing, the Appeal or Grievance;

(3) If an oral filing was received, documentation that the Grievance or Appeal was received orally;

(4) Records of the review or investigation;

(5) Notice of resolution of the Grievance or Appeal; and

(6) All written decisions and copies of all correspondence with all parties to the Grievance or Appeal.

c. Contractor shall submit to OHA upon request, a total number or copies of NOAs sent to Members.

d. Contractor shall review and analyze the Grievance System, including all Grievances and Appeals. The analysis of the Grievance System shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards as follows:

(1) Review of completeness, accuracy and timeliness of documentation,

(2) Compliance with written procedures for receipt, disposition, and documentation and

(3) Compliance with applicable OHP rules.

Exhibit J – Readiness Review

Before the Effective Date of this Contract, OHA will conduct a readiness review to determine Contractor's readiness to serve Medicaid beneficiaries. Contractor shall make available for review by OHA (a) all of the documents listed on Attachment 1 to this Exhibit J, (b) any other documents Contractor listed, in response to questions A.I.s and E.1.2.a of the RFA, as deferred documents that it planned to submit by the readiness review document due date, and (c) any other documents OHA may request be available for review.

OHA will determine which documents must be available electronically, which will be available for OHA review at Contractor's office, and which will be available for OHA review at OHA's offices. For review at Contractor's office, Contractor shall furnish a work room, that has door and telephone, that is not used by others during OHA's review, and that is available to OHA throughout Contractor's business hours. Unless otherwise specified by OHA in writing, Contractor shall have its readiness review documentation available to OHA starting on the earlier of (a) one month before the Medicaid effective date set forth in Section I.A.1 above, or (b) the date specified by OHA. Contractor shall make photocopies at its expense of any readiness review documents requested by OHA.

If Contractor considers any portion of a readiness review document a trade secret as defined in Oregon Revised Statutes 192.501(2) or otherwise exempt from disclosure under Oregon Public Records Law, in order to seek protection from disclosure the Contractor shall, before the time of readiness review, provide a Designation of Confidential Materials in substantially the form of Attachment 2 to the RFA. Contractor's Designation of Confidential Materials must clearly designate that portion as confidential in Part I and must explain the justification for exemption under the Oregon Public Records Law in Part II. After review of Contractor's Designation of Confidential Materials as submitted, OHA may redact portions of the Application if it determines that confidential information claimed to be exempt is in fact exempt from disclosure. Contractor shall furnish redacted copies of any document requested by OHA. Interpretation of the Oregon Public Records Law, as determined by OHA upon advice of the Oregon Department of Justice, shall determine if the confidential information claimed to be exempt is in fact exempt from disclosure. OHA may release information notwithstanding its being in fact exempt from disclosure. OHA will not be liable to Contractor or any other person for release of information Contractor claims to be confidential.

If OHA determinates, after its readiness review, that Contractor is ready to serve Medicaid beneficiaries, OHA will issue a notice to proceed to Contractor. The notice to proceed will confirm the Effective Date of Contractor's Contract to serve Medicaid beneficiaries. If OHA determinates, after its readiness review, that Contractor is unready to serve Medicaid beneficiaries, OHA will not issue a notice to proceed to Cotnractor, and the effective date of Contractor's Contract to serve Medicaid beneficiaries will be delayed.

Exhibit J – Attachment 1 - Readiness Review Checklist

Following is a list of requirements necessary for successful completion of the readiness review, and to become eligible to receive a notice to proceed.

Contractor's responses to the issues below must be detailed, comprehensive, and descriptive of the actions that will be taken. Non-specific generalizations are unlikely to meet the standards of readiness review.

Section 2 identifies the standard items required for readiness review. Section 3 identifies the items, in addition to the standard requirements, needed for readiness review based on gaps in Contractor's application under RFA 3402.

1. High Priority for Early Response for Readiness Review: Governance and Community Advisory Council (due July 24)

Contractor shall demonstrate that its governance structure and community advisory council addresses statutory requirements.

a. Governance Structure and Community Advisory Council

Contractor shall furnish the following:

(1) Documentation about the governance structure and how it meets statutory requirements. Contractor shall include the names, positions, and roles of each member of its governance structure, so OHA can verify with the Contractor that the roles/relationships required for the governance structure are consistent with statutory requirements (See ORS 414.625(3)(o), as amended by SB 1580 (2102), Section 20). ...

(2) Documentation about the Community Advisory Council (CAC) and how it meets statutory requirements for CAC members and the selection process described in SB 1580 (2012), Section 13. Contractor shall include the names, positions, and roles of each member of its CAC and information about the process by which CAC members were selected, consistent with SB 1580 Section 13. OHA will verify with the Contractor that the roles/relationships required for the CAC and for the selection process are consistent with statutory requirements.

(3) Resumes for key leadership personnel: Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Medical Director, and Behavioral Health Director.

(4) A legal opinion from legal counsel to the CCO, in customary form addressed to OHA and effective as of the date of the Contract. The legal opinion will cover the corporate status of the CCO entity (due organization, valid existence, and good standing), the corporate action on the Contract (corporate power to conduct business and enter into the contract, and due authorization, execution and delivery of the contract, including a substantive non-consolidation opinion), and no-violation opinions (articles and bylaws, material agreements, government orders). OHA will furnish a sample form of acceptable legal opinion.

b. Documentation of public presentation by Contractor, unless those documents have been previously submitted, including:

(1) Date, location, time;

(2) Agenda, number of attendees, description of who was invited; and

(3) Summary of public input.

2. Standard Readiness Review Requirements (due July 24, 2012)

For all timelines and activities, identify and designate the Contractor's unit or position title of the person that is accountable for assuring that these activities are implemented. If Contractor has submitted any of the information in the original application to RFA 3402, provide the specific citation for OHA's review and consideration.

a. Meeting the Needs of Members

Contractor shall furnish documents to OHA to demonstrate that on the Effective Date of this Contract, it will be able to:

(5) Identify and assure that each Member has a PCP or primary care team that is responsible for coordination of care and transitions;

(6) Identify and reach out to special needs Members, those Members with chronic and persistent mental illness, and those Members receiving home and community-based care and long-term care to assure that gaps in care or services do not occur; and

(7) Have a communications system in place to answer Member questions (including communication in the prevalent language and for persons with disabilities) and provider questions.

b. Financial and Clinical Integration

(1) Contractor shall furnish documents to OHA that establish the extent to which the Contractor is financially integrated at the Contractor level. Examples of appropriate documents include, but are not necessarily limited to:

(a) Evidence of capital contribution, risk sharing, or other financial arrangements between the Contractor and its affiliates;

(b) If the Contractor will have arrangements with risk-bearing health plans other than the Contractor itself (e.g. an existing FCHP or MHO, a Medicare Advantage Plan, or a health insurer), documents that establish the extent to which these arrangements are financially integrated at the Contractor level through capital contribution, risk sharing, or other financial arrangements; and

(c) Documents that establish the extent to which the Contractor's major providers (hospitals, Physician groups, etc.) share substantial financial risk with the Contractor through alternative reimbursement arrangements (e.g. subcapitation, percentage of premium, withholding, bundled or episode payments, etc.).

(2) Contractor shall furnish documents to OHA that establish the extent to which the Contractor is clinically integrated at the Contractor level. Examples of appropriate documents include, but are not necessarily limited to:

(a) Policies, shared clinical guidelines, electronic record sharing, or other arrangements that will coordinate and integrate a Member's care by multiple unrelated providers; and

(b) If the Contractor will have arrangements with risk-bearing health plans other than the Contractor itself (e.g. an existing FCHP or MHO, a Medicare Advantage Plan, or a health insurer), documents that establish the extent to which these arrangements are clinically integrated at the Contractor level through policies, shared clinical guidelines, electronic record sharing, or other arrangements that will coordinate and integrate a Member's care by multiple affiliated health plans.

(3) Contractor shall provide to OHA copies of policies, procedures and monitoring systems for:

(a) Access to non-participating service providers and for services not available in Service Area;

(b) 24/7 Urgent Care Services, Emergency Services and Post-Stabilization Services;

(c) Prior authorization and coordination of care, including authorization of flexible services;

(d) Grievance System, including complaints and Appeals;

(e) Assessment of any Member suspected of having a significant mental, substance use or emotional disorder, and facilitating provision of care;

(f) Communication for people with disabilities or limited English proficiency or diverse cultural and ethnic backgrounds; and

(g) Formal certification or qualification of health care interpreters.

c. Financial Documentation

Contractor shall furnish to OHA all documents in the nature of guaranties, subordinated surplus notes, or other instruments intended to enhance the capital position and reserves of the Contractor, unless those documents have been previously submitted with the Application to RFA 3402.

d. Documents Deferred by Contractor

Contractor shall furnish to OHA all documents that Contractor listed in its Application to RFA 3402, in response to questions A.I.s and E.1.2.a, as deferred documents that it plans to submit by the readiness review document due date.

e. Provider Relations

Contractor shall furnish the following:

(1) Participating provider tables

(2) Attestation of executed provider, facility, pharmacy and supplier contracts to assure access and availability throughout entire service area for providers listed on the participating provider table

(3) Fifteen calendar days after the notice to proceed, OHA will require a sample of the following, based on the participating provider tables provided in subsection (1), that includes:

(a) Template for each different contract type (e.g., hospital, facility, provider, supplies, specialty care, if different);

(b) Signature page for a sample of providers on the panel;

(c) Verification that each provider in the sample meets credential requirements and has not been excluded from participation in the Medicaid program;

(4) Memorandum of Understanding with AAA/APD offices in the Service Area;

(5) Memorandum of Understanding with local community mental health authority in the Service Area; and

(6) Agreements with Indian Health Services (IHS) or tribal entities that provide health, substance use disorder or behavioral health services to Members in the Service Area, or identification of such entities and documentation of Tribe's decision to not contract with Contractor. (Contact info for tribes serving Contractor's area are located on OHA's CCO website.).

Upon request and with a showing of good faith effort, OHA may grant exceptions to subsections (4), (5) and (6) of this section, subject to the requirement that any items not provided during Readiness Review must be addressed in the Transformation Plan required in Exhibit K.

3. Further Information Required (Due July 24, 2012)

a. The proposed organizational structure of the Contractor does not appear to meet the statutory requirements of HB 3650 with respect to a single point of accountability for a global budget and a fully integrated delivery system. In order to issue a Notice to Proceed, the Oregon Health Authority requires a clear plan with timelines and milestones for transforming the Contractor into an organization that can effectively manage the coordination and integration of services across all providers and plans in the CCO network. The Member must be associated with the Contractor, not with the individual organizations that comprise the Contractor and must be able to rely on the Contractor as the sole administrator of the Contractor. The Oregon Health Authority must be able to rely on the Contractor as the sole point of contact for all interactions between the OHA and the Contractor. The Contractor must have complete financial accountability for all liabilities of the Contractor.

b. Describe how care management strategies for diverting unnecessary inpatient psychiatric admissions and decreasing lengths of stay will be developed and implemented across the network.

Exhibit K – Transformation Plan

Contractor shall prepare a "Transformation Plan" that is a specific plan (plans, timeline, benchmarks, milestones, and deliverables) demonstrating how and when Contractor will achieve Health System Transformation. The purpose of this Exhibit K is to set forth the procedure Contractor shall follow to prepare the Transformation Plan required by this Contract.

1. Initial Transformation Plan

a. Contractor shall provide the following deliverables, and OHA will respond to these deliverables, on the schedule describe below:

	Deliverable	Deliverable Date
(1)	Draft Plan. Contractor furnishes OHA with a draft of a Transformation Plan.	45 days after the Effective Date
(2)	OHA Comments. OHA furnishes Contractor with written comments on its draft Transformation Plan.	60 days after the Effective Date
(3)	Final Draft. Contractor submits final draft language of its Transformation Plan for approval by OHA.	75 days after the Effective Date
(4)	OHA Acceptance. OHA furnishes Contractor with written approval of its draft Transformation Plan.	90 days after the Effective Date

b. Contractor's Transformation Plan must include, at minimum:

(1) Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions. This plan must specifically address the needs of individuals with severe and persistent mental illness.

(2) Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

(3) Implementing consistent alternative payment methodologies that align payment with health outcomes.

(4) Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with SB 1580 (2012), Section 13.

(5) Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.

(6) Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguisitic needs.

(7) Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, non-traditional health care workers composition reflects Member diversity).

(8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Contractor's Transformation Plan may include any other elements that are part of Contractor's strategy for Health System Transformation.

Following review and written approval of the Transformation Plan by OHA, and following any necessary approval by DOJ or CMS, the Transformation Plan is incorporated in this Contract by this reference, and Contractor's obligations under the Transformation Plan are obligations under this Contract.

If Contractor does not have an OHA-approved Transformation Plan by 90 days after the Effective Date, Contractor shall continue to negotiate with OHA regarding the Transformation Plan. Contractor's failure to have an OHA-approved Transformation Plan by 120 days after the Effective Date is a material breach of this Contract under Exhibit D, Section 10.a(3) of this Contract.

2. Revised Transformation Plan.

At OHA's request, or as required by an amendment to the Contract, Contractor shall make changes to its Transformation Plan by furnishing OHA with a revised draft of the Transformation Plan with the requested changes. Contractor and OHA will exchange deliverables pursuant to the schedule set forth in Section 1 above, except that "Effective Date" will refer to the effective date of the OHA-requested change or the amendment to the Contract.

3. Renewal of Contract.

Upon any renewal of this Contract, OHA will move elements of Health Care Transformation that are due to be performed by or before the renewal date into the Statement of Work of this Contract and will amend the Transformation Plan to reflect Contractor's progress toward Health System Transformation.

4. Monitoring and Compliance Review

Contractor agrees to progress toward achieving the objectives and timelines identified in its Transformation Plan and to cooperate with OHA in providing evidence of progress consistent with the Plan. OHA may monitor Contractor's compliance with the requirements in its Transformation Plan and with other elements of Health System Transformation in the Statement of Work. Contractor shall make records and facilities available for OHA's compliance review, consistent with Exhibit D, Section 13 of this Contract.

The requirements of this Exhibit K are in addition to any other requirements in this Contract for timeliness, accuracy and completeness of data reporting required to be submitted under the Contract, including but not limited to encounter data, paid claims data, and data related to performance and quality outcome measures. Where specific processes for monitoring and compliance are specified in Exhibit B, Part 8, or other portions of the Statement of Work, those specific processes will be followed.

The parties intend to work together to monitor Contractor's progress in achieving its Transformation Plan. If OHA cannot confirm Contractor's progress toward compliance with its Transformation Plan, OHA will give the Contractor opportunity to demonstrate evidence of progress and compliance with its Transformation Plan before seeking to impose Sanctions under Exhibit D, Sections 32 through 35, of this Contract, and to pursue other remedies available under this Contract.

Exhibit L – Solvency Plan and Financial Reporting

A. Overview of Solvency Plan and Financial Reporting

1. Background/Authority:

Contractor shall maintain sound financial management procedures and demonstrate to OHA through proof of financial responsibility that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract and OAR 410-141-3340 through 410-141-3395. As part of the proof of financial responsibility, Contractor shall provide assurance satisfactory to OHA that Contractor's provisions against the risk of insolvency are adequate to ensure the ability to comply with the requirements of this Contract.

Reporting forms and other tools for Contractor's solvency plan and financial reporting are posted on OHA's CCO contract reports web site, https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx (the "Contract Reports Web Site"), and are by this reference incorporated into the Contract.

2. Methods for Solvency Plan Financial Reporting:

This Contract provides for three different methods for Contractor's solvency plan and financial reporting requirements, depending on the status of Contractor as described in Subsection 3 below.

a. **OHA Approval**: Restricted Reserve and Net Worth requirements historically used to regulate financial solvency of MCOs, as detailed in Section B of this Exhibit. Under this approach, the OHA will continue to monitor financial solvency utilizing the same reporting format and financial standards that OHA uses for MCOs.

b. **DCBS Approval**: Financial requirements as detailed in Section C of this Exhibit, including Risk Based Capital and NAIC reporting requirements. These requirements are also described in OAR 410-141-3340 through 410-141-3395, and will be monitored by DCBS.

c. **DCBS Certificate of Authority as a Licensed Insurer:** Financial reporting and solvency requirements pursuant to applicable DCBS requirements under the Oregon Insurance Code and DCBS rules. In addition, the Contractor shall also report to OHA the schedules outlined in Section C.1.h. and i. of this Exhibit.

3. Contractor Status:

The method described in Subsection 2 above that applies to Contractor is determined as follows:

a. If Contractor is a Licensed Insurer, Contractor shall use method c (DCBS Certificate of Authority as a Licensed Insurer). Contractor shall submit to OHA not later than Readiness Review for initial contract approval, and annually, not later than August 31st, a copy of the Certificate of Authority number and certificate applicable to Contractor by DCBS. Contractor shall report to OHA immediately at any time that this DCBS authority is suspended or terminated.

b. If Contractor is neither a Converting MCO nor a Licensed Insurer, Contractor shall use method b (DCBS Approval).

c. If Contractor is a Converting MCO and is not a Licensed Insurer, Contractor shall elect either method a (OHA Approval) or method b (DCBS Approval). Contractor shall notify OHA of its election no later than the Readiness Review deadline identified in Exhibit J, Attachment 1, Section 1. Contractor shall comply with the requirements applicable to its elected method until it notifies OHA of its intent to change its election. If Contractor expects to change its election, any elements of the solvency plan or solvency protection arrangements, Contractor shall provide written advance notice to OHA, per 42 CFR 438.116 at least 90 calendar days before the proposed effective date of change. Such changes are subject to written approval from OHA.

d. For purposes of this Exhibit L, "Converting MCO" means a CCO that:

(1) Is the same legal entity as a contractor that held an MCO contract immediately prior to the Effective Date of this Contract ; or

(2) Was formed by one or more contractors that held MCO contract(s) immediately prior to the Effective Date of this Contract.

B. OHA Approval of Solvency Plan and Financial Reporting

This Section B applies only if the Contractor uses the OHA Approval process for its solvency plan and financial reporting.

1. Glossary of Terms:

a. **Average Fee-For-Service Liability** - The Average Monthly Fee-For-Service Liability is the cost of health care services that are offered by Contractor to Members that would be owed to creditors in the event of Contractor's insolvency. These are expenditures for health care services for which Contractor is at risk and will vary in type and amount. These services may include out-of-area services, primary care services, referral services, and hospital services. Determination of the cost is based on the usual and customary fee schedule of Contractor and is developed for the anticipated Capitated Services liability. Anticipated monthly non-service liabilities (such as insolvency insurance, hold harmless contracts liabilities, regulated and non-regulated guarantees liabilities, and other liabilities) are not included.

b. **Corporate Activity** - the financial position of a corporation relating to activities the corporation performs. Includes the OHP line of business. If Contractor is not a corporation it should regard its total OHP Business as corporate activity.

c. **Financial solvency** - the collection of resources belonging to a company and the sources of these resources or claims on them at a particular point of time.

d. **Medical Loss Ratio, Restricted Reserve** - represents that portion of total medical and hospital expenditures after reinsurance recoveries incurred, co-payments, COB and Subrogation for Covered Services to Members, either unadjusted or adjusted for medical sub-capitation expenditures, divided by total OHP Revenues for which Contractor is at risk.

e. **Medical Loss Ratio, Net Worth** - represents that portion of total medical and hospital expenditures before reinsurance recoveries incurred, co-payments, COB and Subrogation for Covered Services to Members, adjusted for medical sub-capitation expenditures, divided by total OHP Revenues for which Contractor is at risk.

f. **Member Months** - calculation, obtained from Report L.1, which represents Contractor's average number of Members during the quarter.

g. **Net Premiums** - calculation obtained from Report L.1 which represents Contractor's average OHP Capitation Rate and case rates paid (net of reinsurance premiums paid, HRA and GME payments and MCO tax expenses) per Member during the reporting period.

h. **OHP Business** - activities Contractor performs that relate to this Contract.

i. **Quarterly Financial Reports** – financial and utilization information filed quarterly, covering the time periods defined on each report.

j. **Receipt of the Appeal** - the date that the appeal document is delivered to OHA, Delivery Services Unit and is date-stamped.

2. Audited Financial Statements:

Contractor shall submit Audited Financial Statements to OHA no later than June 30th following the last day of each calendar year that this Contract is in effect, except as otherwise specified herein. Audited Financial Statements shall be prepared by an independent accounting firm and shall include, but are not limited to, the following information:

a. A statement of opinion by the independent accounting firm about the financial statements based on the results of their audit;

b. A statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities and related items;

c. Balance Sheet(s). The information specified in Report L.5 shall be included in the Audited Yearly Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. Amounts reported on Report L.5 shall equal the amounts previously reported to OHA on Report L.7 for the 4th quarter of the calendar year. Contractor shall amend the 4th quarter Financial Report for audit adjustments and submit to OHA no later than June 30th, following the last day of each calendar year that this Contract is in effect.

d. Statement of Revenue, Expenses and Changes in Fund Balance. The information specified in Report L.6 shall be included in the Audited Yearly Statement of Revenue, Expenses and Changes in Fund Balance or the accompanying Notes to Financial Statements. Amounts reported on Report L.6 shall equal the amounts reported to OHA on Report L.8 for the 4th quarter of the calendar year. Contractor shall amend prior Quarterly Financial Report L.8 for audit adjustments and submit to OHA no later than June 30th, following the last day of each calendar year that this Contract is in effect.

e. Statement of Cash Flow. The information specified in Report L.9 shall be included in the Audited Cash Flow Analysis for Corporate Activity or the accompanying Notes to Financial Statements. Contractor shall allocate cash flow using the Indirect Method of Accounting, as described by GAAP.

f. Notes to Financial Statements.

g. Any supplemental information deemed necessary by the independent accounting firm, actuary or OHA.

h. Audited Financial Statements and the accompanying Notes to Financial Statements shall include information specified in Reports L.5, L.6, and L.9 on the Contract Report Web Site. Contractor shall use Generally Accepted Accounting Principles (GAAP) to define the information requested.

i. Contractor shall disclose to OHA within the notes of the Annual Audited Financial Reports any sale, exchange or lease of any property, any lending of money or other extension of credit and any furnishing for consideration of goods, services or facilities between the Contractor and any party of interest, excluding regular business operation administrative expenses, such as compensation and bonuses made to personnel. Party of interest is defined as 1) any director, officer, partner, affiliate, or employee responsible for management or administration of the Contractor, 2) any person who is directly or indirectly the beneficial owner of more than 5% of the net worth of the Contractor, 3) any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the Contractor, or 4) an incorporator or member of the Contractor entity under applicable state law.

3. Quarterly Financial Reports:

Contractor shall report results of financial operations to OHA quarterly unless annotated as an annual requirement only. The reports identified below are posted on the Contract Reports Web Site and shall be referred to collectively as the Quarterly Financial Reports. Definitions and instructions for completing each report identified below have been posted on the Contract Reports Web Site.

a. Quarterly Financial Reports include, but are not limited to, the following:

(1) Form L.1: General Information and Certification,

(2) Report L.1: Restricted Reserves; attach verification of account balances,

(3) Report L.2: Members Approaching or Surpassing Stop-Loss Deductible,

(4) Report L.4: OHP Access to Services Statistics,

(5) Report L.7: Quarterly Balance Sheet of Corporate Activity,

(6) Report L.8: Quarterly Statement of Revenue, Expenses and Net Worth,

(7) Report L.8.1: Net Worth Adjusted Medical Loss Ratio,

(8) Report L.9: Cash Flow Analysis for Corporate Activity, and

(9) Report L.10: Corporate Relationship of Contractors (Parts I, II and IV) (Part III is an annual requirement only, due August 31st of the following year).

b. OHA will supply Contractor with an Excel spreadsheet containing the Quarterly Financial Reports. Contractor shall submit the Quarterly Financial Reports to OHA in an electronic format approved by OHA. Contractor has the option of submitting the Excel spreadsheet to OHA either electronically or by mailing a diskette containing the Quarterly Financial Reports to OHA.

c. Contractor shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to OHA 60 days after the end of each calendar quarter. Contractor shall submit the Quarterly Financial Reports for the 4th quarter three calendar months after the end of the calendar quarter, as follows:

End of Quarter	Due Date of Report
March 31st	May 31st
June 30th	August 31st
September 30th	November 30th
December 31st	March 31st

d. Contractor shall use Generally Accepted Accounting Principles (GAAP) to define the information requested.

e. Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted Quarterly Financial Reports. If the material change in circumstances requires restatement of prior Quarterly Financial Reports, Contractor shall amend the Quarterly Financial Reports and submit to OHA within 15 working days of the date the material change is identified.

f. Reports annotated as an annual requirement only will include all data from the prior calendar year and are due on the dates specified on the reports.

4. Annual Reporting Requirements

a. Contractor shall submit Report L.11 "Disclosure of Compensation" in an electronic format acceptable to OHA. The Disclosure of Compensation Report shall be submitted to OHA by March 31st of each Contract year.

b. Contractor shall file the Detailed Analysis of Operations Exhibit developed by OHA to provide detailed breakdown of operating expenses needed to monitor the CCO's progress in meeting the objectives of Health System Transformation. The exhibit and instructions are included on the Contract Reports Web Site.

c. Contractor shall file the Sources and Uses of Funds Exhibit developed by OHA to provide an accounting of the source and use of public funds and to further transparency and accountability of Contractor to OHA and the public. The exhibit and instructions are included on the Contract Reports Web Site.

5. Assumption of Risk/Private Market Reinsurance:

Contractor assumes the risk for providing the Coordinated Care Services required under this Contract. Contractor shall obtain risk protection in the form of stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to Coordinated Care Services to Members.

a. Contractor shall submit Report L.2, Part I, along with the Quarterly Financial Reports, due May 31st, August 31st, November 30th and March 31st. Contractor shall report Members approaching or surpassing the deductible amount of stop-loss or reinsurance. Report L.2 contains instructions necessary to complete the form.

b. At the time of application, or within 30 days of signing this Contract, and thereafter at the time of filing the second Quarterly Financial Report on August 15th, Contractor shall report to OHA on Report L.2, Part II, the deductible amounts and the amount and associated type of stop-loss or reinsurance coverage (e.g., hospital, medical or aggregate coverage), and the dollar amount or percentage of Claim amount whereby responsibility for covering the Claim reverts back to the Contractor from the re-insurer.

6. Restricted Reserve Requirement:

Contractors, unless exempt, shall establish: 1) Restricted Reserve Account and 2) maintain adequate funds in this account to meet OHA's Primary and Secondary Restricted Reserve requirements. Reserve funds are held for the purpose of making payments to Providers in the event of the Contractor's insolvency. The reserves discussed within this Contract cover only Capitated Services provided by Contractor notwithstanding Restricted Reserve amounts required to be maintained pursuant to separate contracts with the Department of Human Services.

a. **Restricted Reserve Account:** Contractor shall establish a Restricted Reserve Account with a third party financial institution for the purpose of holding Contractor's Primary and Secondary Restricted Reserve Funds. Contractors shall use the Model Depository Agreement to establish a Restricted Reserve Account.

(1) **Model Depository Agreement** shall be used by the Contractor to establish a Restricted Reserve Account. Contractor shall request the Model Depository Agreement form from OHA. Contractor shall submit the Model Depository Agreement to OHA at the time of application and the Model Depository Agreement shall remain in effect throughout the period of time that this Contract is in effect. The Model Depository Agreement cannot be changed without OHA's written authorization.

(2) **Withdrawal of Funds from a Restricted Reserve Account:** The Contractor shall not withdraw funds, change third party financial institutions, or change account numbers within the Restricted Reserve Account without the written consent of OHA.

(3) **Filing requirements:** Contractor shall submit a copy of the Model Depository Agreement at the time of application. If Contractor requests and receives written authorization from the OHA to make a change to their existing Restricted Reserve Account, Contractor shall submit a Model Depository Agreement reflecting the changes to OHA within 15 days of the date of the change.

(4) **Eligible Deposits:** The following instruments are considered eligible deposits for the purposes of OHA's Primary and Secondary Restricted Reserves:

(a) Cash,

(b) Certificates of Deposit,

(c) Amply secured obligations of the United States, a state or a political subdivision thereof as determined by OHA, or

(d) A Surety Bond provided it meets the requirements listed below:

(i) Such a bond is prepaid at the beginning of the Contract year for 18 months;

(ii) Evidence of prepayment is provided to OHA;

(iii) The Surety Bond is purchased by a surety bond company approved by the Oregon Insurance Division;

(iv) The Surety Bond Agreement contains a clause stating the payment of the bond will be made to the third party entity holding the Restricted Reserve Account on behalf of the contracting company for deposit into the Restricted Reserve Account;

(v) The Surety Bond Agreement contains a clause that no changes to the Surety Bond Agreement will occur until approved by OHA; and

(vi) OHA approves the terms of the Surety Bond Agreement.

b. **Primary and Secondary Restricted Reserves:** Contractor's Primary and Secondary Reserve balances are determined by calculating the Average Fee-For-Service Liability for Capitated Services using either of the following methods: A) Enrollment Data, or B) Historical Expense Data. The Average Fee-For-Service Liability represents the cost of Covered Services that are offered by the Contractor to Members that would be owed to creditors in the event of the Contractor's insolvency. These are expenditures for Covered Services for which Contractor is at risk. These services may include out-of-area services, primary care services, referral services, and hospital services. Determination of the cost is based on the usual and customary fee schedule of Contractor that has been developed to approximate the estimated Capitated Service Liability of the Contractor. Contractor shall deposit into the Restricted Reserve Account the amount required by Paragraph (3) and (4), of this subsection.

(1) **Average Fee-For-Service Liability based on Enrollment Data:** If Contractor elects to calculate reserve balances based on Enrollment Data, Contractor shall complete Report L.1, Part I and II. The Average Fee-For-Service Liability is calculated by multiplying the Average Capitation Rate times the Average Monthly Members times the Medical Loss Ratio, as follows:

Step 1: Enter the following data:

Net Premiums: Net Premiums received for each month of the calendar quarter, Exhibit C, Attachment 2, less the adjustments shown on Report L.8, lines 1(a) through 1(d). If Contractor provides services in more than one service area, use the capitation rate for the service area with the largest number of monthly Members in the third month.

Member Months: Contractor's average number of Members during the quarter

Medical Loss Ratio (Restricted Reserve): Contractor may elect to use either the Adjusted or Unadjusted Medical Loss Ratio, whichever method Contractor elects to use to determine the Medical Loss Ratio shall be used throughout the Contract year. The Medical Loss Ratio is determined for purposes of calculating the fee-for-service liability:

Step 2: Determine the Medical Loss Ratio (Restricted Reserve):

(a) Restricted Reserve, Adjusted Medical Loss Ratio:

	Total Medical and Hospital Operating Expenses, (Report L.8, Line 20)
Less:	Subcapitation or Salaried Medical Expenses (Report L.10.II, Columns A, C, D, E, F and G)
	Divided by: Total Operating Revenues (Report L.8, Line 6)

(b) Restricted Reserve, Unadjusted Medical Loss Ratio:

	Total Medical and Hospital Operating Expenses, (Report L.8, Line 20)
Divided by:	Total Reporting Revenues (Report L.8, Line 6)

Step 3: Calculate the Average Fee-For-Service Liability. The Excel spreadsheet provided by OHA will calculate the following:

	Average Net Premiums
Times:	Average Members Months
Times:	Medical Loss Ratio.
Equals:	Average Fee-For-Service Liability

(2) **Average Fee-for-Service Liability based on Historical Expense Data:** If Contractor has submitted Report L.8, Quarterly Statements of Revenue, Expenses, and Net Worth under this Contract for the current quarter and the prior 3 quarters, Contractor is eligible to use the Historical Expense Data method. The Average Fee-For-Service Liability is an average of the prior four quarters Historical Expense Data. No form has been provided. OHA will calculate a Contractor's Average Fee-For-Service Liability using the Historical Method as follows:

(a) Average of: (current quarter plus 3 prior quarters) Medical/Hospital/Dental Operating Expenses Less Deductions (Report L.8 Line 20),

(b) Average (current quarter plus 3 prior quarters) Capitation Payment Expenses (Report L.10.II, Columns C, D, E, F and G); Plus: Salary Service Payment Expenses (Report L.10.II, Column A).

(c) Subtract line 2 from line 1.

(d) Divide line 3 by the number of months in a quarter or 3.

(3) **Determine Primary Reserve**: If Contractor's Average Fee-For-Service Liability is less than or equal to $250,000, Contractor shall deposit into the Restricted Reserve Account an amount equal to the Average Fee-For-Service Liability from Report L.1. This amount will be referred to as the Contractor's Primary Reserve and Contractor shall have no Secondary Reserve, until such time as the Average Fee-For-Service Liability exceeds $250,000.

(4) **Determine Secondary Reserve**: If Contractor's Average Fee-For-Service Liability is greater than $250,000, Contractor is required to deposit into the Restricted Reserve Account funds equaling 50 percent of the difference between the Average Fee-For-Service Liability and the Primary Reserve balance of $250,000.

7. Net Worth Requirements:

Contractors shall maintain a level of Net Worth that will provide for minimum adequate operating capital. A minimum adequate level of Net Worth is defined as the Discounted Premium Revenue to Net Worth ratio less than or equal to 20:1 (premium to surplus ratio). Contractor shall maintain the Minimum Net Worth level, as determined by this section, during the next calendar quarter.

a. **Minimum Net Worth level:** Contractor shall calculate the Minimum Net Worth level by following the steps outlined below:

Step 1: Determine Average Corporate Premium:

	Corporate Premium Revenue for the current period
Add:	Corporate premium revenue for the prior period
Divided by:	2

Step 2: Determine Annualized Average Corporate Premium:

	Average Corporate Premium
Times:	four

Step 3: Determine Adjusted Annualized Average Corporate Premium:

	Annualized Average Corporate Premium
Times:	Medical Loss Ratio (Net Worth), see Step 4, below.

Step 4: Determine the Medical Loss Ratio (Net Worth):

	Medical/Hospital Operating Expenses Subtotal (Report L.8, Line 15)
Less:	Subcapitation or salaried medical expenses (Report L.10.II, Columns A, C, D, E, F and G)
Divided by:	Total Reporting Revenue (Report L.8, Line 6)

Step 5: Determine the Minimum level of Net Worth:

	Adjusted Annualized Average Corporate Premium:
Divided by:	Twenty

b. Contractor is required to retain a dollar amount no less than 2 percent of Contractor's Adjusted Quarterly Corporate Premium Revenues as retained earnings each subsequent quarter until Contractor has a premium to surplus ratio that meets the 20:1 requirement.

c. Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted Quarterly Financial Reports L.8 and L.10. If OHA determines that a Contractor's premium to surplus ratio does not meet the required premium to surplus ratio level of 20:1, OHA will notify Contractor.

d. In lieu of providing 100 percent of the required Minimum level of Net Worth on the Contract Effective Date, Contractor may place up to 50 percent of the Minimum level of Net Worth requirement at contract startup in a Transformation Fund; provided that no amounts in Contractor's Restricted Reserves may be placed in the Transformation Fund. If the Contractor uses its Minimum level of Net Worth in this manner:

(1) Contractor shall file an initial report, before the Contract Effective Date, setting forth Minimum level of Net Worth and the amount placed in the Transformation Fund. Contractor shall thereafter file a quarterly report, due at the same time as its other financial reports to OHA, setting forth Minimum level of Net Worth, the amount in the Transformation Fund, the cumulative amount of Transformation Fund expenditures, and all transactions within the Transformation Fund.

(2) Contractor may use the Transformation Fund only to pay for Health Systems Transformation activities approved by OHA in the plan described in paragraph 4 below. Contractor may use the Transformation Fund to pay for Health Systems Transformation activities only during the total period of twenty four calendar months after the Effective Date of this Contract.

(3) The Minimum level of Net Worth must be restored to 100 percent of the requirements of this Section 7 not later than twenty four calendar months after the Effective Date of this Contract.

(4) Contractor's uses of a Transformation Fund established under this Subsection 7.d must be based on a plan approved by OHA as part of Contractor's Transformation Plan under Exhibit K.

(5) Transformation Fund amount not used for Transformation Plan expenditures must remain part of the Contractor's Minimum level of Net Worth.

8. Appeal Process:

If at any time, OHA believes that Contractor has incorrectly computed the amount of either its Primary or Secondary Restricted Reserve fund, or that Contractor's premium to surplus ratio does not meet the required premium to surplus ratio level of 20:1, OHA will notify Contractor in writing. In the event that OHA believes that the Primary or Secondary Restricted Reserve fund has been incorrectly computed, OHA will notify Contractor of the amount Contractor must maintain as its new Restricted Reserve fund and the basis on which such decision was made. In the event that OHA believes that Contractor's premium to surplus ratio is above the 20:1 ratio, OHA will notify Contractor of the dollar amount of no less that 2 percent of its Adjusted Quarterly Premium Revenue required to be retained each subsequent quarter until Contractor has a premium to surplus ratio that meets the 20:1 requirement.

a. Within 30 calendar days of any notice by OHA under this Section, Contractor shall either:

(1) Adjust its Restricted Reserve funds to the amount specified by OHA and provide OHA with a copy of the restricted reserve statement and updated Schedule A showing the Restricted Reserve balance, adjust its Net Worth to the amount specified by OHA and provide assurances to OHA that it is now maintaining that amount as its Net Worth, or

(2) File an appeal in writing with the OHA Administrator stating in detail the reason for the appeal, and submit detailed financial records that support the alternate amount.

(3) If Contractor files an appeal, OHA shall issue an appeal decision within 45 calendar days of the receipt of the appeal. That decision shall be binding upon Contractor and not subject to further appeal.

b. Contractor shall send all information to be reported under the requirements of this Exhibit to:

MCO Financial Solvency Program Coordinator
Delivery Systems Unit, 3rd Floor E-35
Division of Medical Assistance Programs
500 Summer Street NE
Salem, OR 97301-1077

C. DCBS Approval of Solvency Plan and Financial Reporting

This Section C applies only if the Contractor uses the DCBS Approval process for its solvency plan and financial reporting. Terms used in this Section C are defined in OAR 410-141-3335 to 410-141-3395, incorporated by reference herein.

1. Annual Financial Statements and Supplemental Filings:

Contractor shall submit annual financial statements per OAR 410-141-3360 by March 1 of each year covering the calendar year ending December 31 immediately preceding. All financial statements shall be completed in accordance with NAIC annual statement instructions and shall include supplemental documents as specified therein and as outlined in this section.

a. Contractor shall file the financial statements per the instructions on the NAIC Filings website.

b. Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3340.

c. Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted financial statement. See guidelines for amending the financial statement set forth on the NAIC filings website.

d. In accordance with NAIC annual statement instructions, an Actuarial Opinion shall be included with the annual statement. Such opinion shall be prepared by a qualified actuary appointed by the Contractor's board of directors and shall set forth the actuary's opinion relating to claim reserves and any other actuarial items.

e. Contractor shall prepare and file by March 1 of each year a risk-based capital report as required by 410-141-3355.

f. Contractor shall prepare and file by April 1 of each year a plain-language narrative explanation of the financial statements (Management Discussion and Analysis or "MDA"). Such narrative shall follow the outline and guidance for the Management Discussion and Analysis in the annual statement instructions.

g. Contractor shall prepare and file with its annual statement the NAIC Supplemental Compensation Exhibit.

h. Contractor shall file the Detailed Analysis of Operations Exhibit developed by OHA to provide detailed breakdown of operating expenses needed to monitor the CCO's progress in meeting the objectives of Health System Transformation. The exhibit and instructions are included on the NAIC filings website.

i. Contractor shall file the Sources and Uses of Funds Exhibit developed by OHA to provide an accounting of the source and use of public funds and to further transparency and accountability of Contractor to OHA and the public. The exhibit and instructions are included on the NAIC filings website.

j. Contractor shall file a holding company registration statement ("Form B filing") as required by OAR 410-141-3380. The Form B filing is due annually on or before April 30.

2. Audited Financial Statements:

Contractor shall submit Audited Financial Statements prepared based on Statutory Accounting Principles to DCBS no later than June 1st for the year ended December 31 immediately preceding. Audited Financial Statements shall be prepared as required by OAR 410-141-3360 and by reference to ORS 731.488 and OAR 836-011-0100 through 836-011-0220.

3. Quarterly Financial Reports:

Contractor shall submit quarterly financial statements per OAR 410-141-3360. All financial statements shall be completed in accordance with NAIC annual statement instructions and includes supplemental documents as specified therein and as outlined in this section.

a. Contractor shall file the financial statements per the instructions on the NAIC filings website.

b. Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3340.

c. Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted financial statement. See guidelines for amending the financial statement set forth on the NAIC filings website.

d. Contractor shall prepare and file with each quarterly statement a plain-language narrative explanation of the financial statements (Management Discussion and Analysis "MDA"). For purposes of preparing the quarterly MDA, the Contractor may presume that the user has read or has access to the annual MDA. Such narrative shall follow the outline and guidance for the MDA in the NAIC instructions.

e. Contractor shall file the Detailed Analysis of Operations Exhibit developed by OHA to provide detailed breakdown of operating expenses needed to monitor the Contractor's progress in meeting the objectives of Health System Transformation. The exhibit and instructions are included on the NAIC filings website.

f. Contractor shall file the Sources and Uses of Funds Exhibit developed by OHA to provide an accounting of the source and use of public funds and to further transparency and accountability of Contractor to OHA and the public. The exhibit and instructions are included on the NAIC filings website.

4. Assumption of Risk/Private Market Reinsurance:

Contractor assumes the risk for providing the Coordinated Care Services required under this Contract. Contractor shall obtain risk protection in the form of stop-loss or reinsurance coverage against catastrophic and unexpected expenses related to Coordinated Care Services to Members.

a. The method of protection may include the purchase of catastrophic expense stop-loss coverage or re-insurance by an entity authorized to insure or to reinsure in this State not inconsistent with ORS Ch. 731, and shall be documented within 30 days of signing this Contract.

b. Contractor shall notify OHA of any change in the coverage in item 1 above within 30 days of such change.

c. Contractor understands and agrees that in no circumstances will a Member be held liable for any payments for any of the following:

(1) The Contractor's or Subcontractors' debt due to Contractor's or Subcontractors' insolvency;

(2) Coordinated Care Services authorized or required to be provided under this Contract to the Member, for which:

(a) The State does not pay the Contractor; or

(b) The Contractor does not pay a Provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or

(3) Payments for Covered Services furnished under a contract, referral or other arrangement with contractors, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

Nothing in this Paragraph (5) Item (d), limits Contractor, OHA, a Provider or Subcontractor from pursuing other legal remedies that will not result in Member personal liability for such payments.

5. Restricted Reserve Requirement:

Contractors, unless exempt, shall establish: 1) Restricted Reserve Account and 2) maintain adequate funds in this account to meet OHA's Primary and Secondary Restricted Reserve requirements. Reserve funds are held for the purpose of making payments to Providers in the event of the Contractor's insolvency. The reserves required by this Contract cover only Coordinated Care Services provided by Contractor notwithstanding Restricted Reserve amounts required to be maintained pursuant to separate contracts with the DHS. See OAR 410-141-3350 for the requirements for the restricted reserve.

6. Net Worth Requirements:

Contractors shall maintain the amount of capital and surplus and working capital as provided in OAR 410-141-3350. Contractor shall maintain at all times the required minimum capital and surplus.

Contractors that are licensed by DCBS shall maintain capital and surplus as provided in the Insurance Code.

7. Financial Statement Filing Information and Resources

a. Filing instructions and resources are provided at the NAIC filings website.

b. CCOs will file the National Association of Insurance Commissioners Annual and Quarterly Blank for Health insurers. Electronic files will be sent to the NAIC and two hard copy filings will be sent to DCBS.

c. A list of NAIC filing software vendors is included on the web site mentioned above.

d. CCOs will be subject to any filing fees as imposed by the NAIC to make such filing.

8. Appeal Process:

If at any time, OHA believes that Contractor has incorrectly computed the amount of either its Primary or Secondary Restricted Reserve fund, or that Contractor's capital and surplus does not meet the requirements in OAR 410-141-3350, OHA (or DCBS on behalf of OHA), will notify Contractor in writing.

a. Within 30 calendar days of any notice by OHA under this Section, Contractor shall either:

(1) Adjust its Restricted Reserve funds to the amount specified by OHA and provide documentation in support thereof; and, if required, adjust its Net Worth to the amount specified by OHA and provide documentation in support thereof; or

(2) File an appeal in writing with the OHA Administrator stating in detail the reason for the appeal, and submit detailed financial records that support the alternate amount. If Contractor files an appeal, OHA shall issue an appeal decision within 45 calendar days of the receipt of the appeal. That decision shall be binding upon Contractor and not subject to further appeal.

b. All information to be reported by Contractor under the requirements of this Exhibit L, shall be sent to:

Financial Regulation Section
Insurance Division
Department of Consumer & Business Services
P. O. Box 14480
Salem, OR 97309-0405

Exhibit M –Benefits and Covered Services for MHO Members

1. Benefit Package

Contractor shall Provide OHP Plus Benefit Package and OHP Standard Benefit Package of MHO Covered Services to MHO Members consistent with OAR 410-141-0120, 410-141-0520 and 410-141-0480. MHO Covered Services shall be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the Services are provided. Contractor shall ensure that the Services offered are in an amount, duration, and scope that is no less than that furnished to OHP Clients receiving mental health services under FFS. Contractor may cover, for MHO Members, MHO Services that are in addition to those covered under the State plan.

a. OHP Plus Benefit Package

A benefit package with a comprehensive range of Services available to Members who are over the age of 65, the disabled, the TANF population, General Assistance recipients, pregnant women and children under the age of 19. Contractor shall notify MHO Members eligible for the OHP Plus Benefit Package of their responsibility to pay a co-payment for some services as specified in OAR 410-120-1230.

b. OHP Standard Benefit Package

A benefit package that provides basic health care Services for adults who are not otherwise eligible for Medicaid (Families, Adults/Couples). This benefit package has premiums requirements.

c. Flexible Services

The MHO Covered Services described in this Contract may be substituted with and/or expanded to include Flexible Services and Flexible Services Approaches identified and agreed to by Contractor, the MHO Member and, as appropriate, the family of the MHO Member as being an efficacious alternative. When delivering a Flexible Service (as opposed to using a Flexible Service Approach) and the Provider rendering a Flexible Service is not licensed or certified by a state board or licensing agency, or employs personnel to Provide the Service who do not meet the definition for Qualified Mental Health Associate (QMHA) or Qualified Mental Health Professional (QMHP) as described in Exhibit A, Definitions, Contractor shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

2. MHO Covered Service Components

Without limiting the generality of Contractor's obligation to provide MHO Covered Services, the following responsibilities are required of Contractor by law and must be implemented in conjunction with its responsibilities stated above.

a. MHO Emergency and Urgent Care Services

(1) Contractor shall establish written policies and procedures and monitoring systems that provide for MHO Emergency Services for mental health conditions including post-stabilization care services, and MHO Urgent Services for mental health conditions for all

MHO Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114.

The emergency response system must include the necessary array of services to respond to mental health crises, that may include crisis hotline, mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.

Contractor's policies and procedures shall include an emergency response system that provides an immediate, initial and/or limited duration response for potential mental health emergency situations or emergency situations that may include mental health conditions, which consist of: screening to determine the nature of the situation and the person's immediate need for MHO Covered Services; capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation; development of a written initial services plan at the conclusion of the Mental Health Assessment; provision of MHO Covered Services and Outreach needed to address the urgent or emergency situation; and linkage with the public sector crisis services, such as pre-commitment.

(2) Contractor may not require prior authorization for MHO Emergency Services. Contractor provides an after-hours call-in system adequate to Triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.

(3) Contractor shall cover and pay for MHO Emergency Services as provided for in OAR 410-141-3140. Contractor shall cover and pay for MHO post-stabilization services as provided for in OAR 410-141-3140 and 42 CFR 438.114.

b. Mental Health Conditions that may Result in Involuntary Psychiatric Care

(1) Contractor shall make a reasonable effort to provide MHO Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment in lieu of involuntary treatment.

(2) Contractor shall adopt written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the MHO Member and the behavior of the MHO Member meets legal standards for the use of an Emergency Psychiatric Hold.

(3) Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340.

(4) Contractor shall comply with ORS Chapter 426, OAR 309-033-0200 through 309-033-0340 and 309-033-0400 through 309-033-0440 for involuntary Civil Commitment of those MHO Members who are civilly committed under ORS 426.130.

(5) If Contractor believes a MHO Member, over age 18 with no significant nursing care needs due to an Axis III disorder, is appropriate for Long Term Psychiatric Care (state hospital level of care), the Contractor shall request a LTPC determination from the OHA LTPC reviewer.

(6) Contractor shall assure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall also work with the CMHP Director in assigning a civilly committed MHO Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

c. Coordinated Care Services for MHO Members and Long Term Psychiatric Care (LTPC)

(1) Age 17 and Under:

(a) If Contractor believes a MHO Member is appropriate for LTPC, Contractor shall request a LTPC determination from the applicable OHA mental health program. The Medicaid Policy Unit staff will render a determination within seven working days of receiving a completed request, if the MHO Member is age 17 and under, as described in Procedure for LTPC Determinations for MHO Members age 17 and Under, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx;

(b) The AMH Child and Adolescent Mental Health Specialist will respond to Contractor no more than seven working days following the date OHA receives a completed request for LTPC determination form.

(c) Contractor shall work with the AMH Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC (SCIP and SAIP programs).

(d) The MHO Member will remain enrolled with the Contractor for delivery of SCIP and SAIP services. Contractor shall bear care coordination responsibility for the entire length of stay, including admission determination and planning, linking the child and family team and Integrated Community Treatment Service (ICTS) Provider, services provided by LTPC service provider and transition and discharge planning. Contractor shall ensure that utilization of LTPC is reserved for the most Acute and complex cases and only for a period of time to remediate symptoms that led to admission.

(2) Age 18 and over

(a) If Contractor believes a MHO Member:

(i) Age 18 to age 64 with no significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the LTPC reviewer as described in *Procedure for LTPC Determinations for Members Age 18-64*, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx. Adult Mental Health Services Unit staff will render a determination within three working days of receiving a complete request.

(ii) Age 65 and over, or age 18 to age 64 with significant nursing care needs due to an Axis III disorder of an enduring nature, is appropriate for LTPC,

Contractor shall request a LTPC determination from the State hospital-GTS, Outreach and Consultation Service (OCS) Team as described in *Procedure for Long Term Psychiatric Care Determinations for Persons Requiring Geropsychiatric Treatment*, found as the following link: https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx.

(b) A MHO Member is appropriate for LTPC when the MHO Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State hospital or extended care program, or extended and specialized medication adjustment in a secure or otherwise highly supervised environment; and the MHO Member has received all usual and customary treatment, including, if Medically Appropriate, establishment of a Medication Management Program and use of a Medication Override Procedure.

(c) OHA will cover the cost of LTPC of MHO Members age 18 to 64 determined appropriate for such care beginning on the effective date specified below and ending on the date the MHO Member is discharged from such setting.

If a MHO Member is ultimately determined appropriate for LTPC, the effective date of such determination is either:

(i) Within three working days of the date AMH Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons Age 18 to 64 form; or

(ii) The date the State hospital -GTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State hospital-GTS; or

(iii) In cases where OHA and Contractor mutually agree on a date other than these dates, the date mutually agreed upon; or

(iv) In cases where the Clinical Reviewer determines a date other than a date described above, the date determined by the Clinical Reviewer.

In the event Contractor and AMH Adult Mental Health Services Unit staff disagree about whether a MHO Member 18 to 64 is appropriate for LTPC, Contractor may request, within three working days of receiving notice of the LTPC determination, review by an independent Clinical Reviewer. The determination of the Clinical Reviewer will be deemed the determination of OHA for purposes of this Contract. If the Clinical Reviewer ultimately determines that the MHO Member is appropriate for LTPC, the effective date of such determination will be the date specified above Paragraph (c). The cost of the clinical review will be divided equally between Contractor and OHA.

(d) For MHO Members age 18 and older, Contractor shall work with the appropriate AMH Team in managing admissions to and discharges from LTPC for MHO Members who require such care at a State hospital, to ensure that Members are served in and transition into the most appropriate, independent, and integrated community-based setting possible.

(e) For the Member age 18 and over, including those Members in the long term geropsychiatric care at the State hospitals, Contractor shall work with the Member to assure timely discharge from LTPC to the most appropriate, independent and integrated community-based setting possible.

(f) For the MHO Member and the parent or guardian of the MHO Member, the care coordinator and the child and family team will work to assure timely discharge from a psychiatric residential treatment facility to the most appropriate, independent and integrated community-based setting possible.

(g) Contractor shall authorize and reimburse Care Management services that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to MHO Members receiving care through licensed community treatment programs.

(h) Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with administrative rule and statute, and shall coordinate with the CMHP Director in assuring that all statutory requirements are met. Contractor shall work with the CMHP Director in assigning a civilly committed MHO Member to any placement and participate in circuit court hearings related to planned placements, if applicable.

d. Acute Inpatient Hospital Psychiatric Care

(1) Contractor shall provide Acute Inpatient Hospital Psychiatric Care for MHO Members who do not meet the criteria for LTPC.

(2) Contractor shall submit required data through the Oregon Patient/Resident Care System (OPRCS).

(3) Contractor shall require employees or Subcontractors providing Mental Health Services to provide AMH, within 30 days of admission or discharge, with all information required by AMH's most current reporting system, currently "Client Process Monitoring System" (CPMS).

e. Adult Mental Health

(1) Contractor shall develop and implement an adult mental health system that provides cost-effective, comprehensive, person-centered, individualized, integrated community-based care to MHO Members.

(2) Contractor shall provide oversight, care coordination and transition and planning management of MHO Members within the targeted population of AMH to ensure culturally and linguistically appropriate community-based care is provided in a way that MHO Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care.

(3) Contractor shall ensure access to referral and screening at multiple entry points.

(4) Contractor shall adopt policies and procedures to assess all MHO Members who are suspected of having significant mental or emotional disorders.

(5) Contractor shall adapt the intensity, frequency and blend of these services to the mental health needs of the MHO Member, based on a standardized assessment tool approved by OHA.

(6) Contractor shall report outcomes and data via the Adult Mental Health Initiative reporting tool.

f. Children's Mental Health

Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care for MHO Members 17 and under, in the care and custody of DHS Child Welfare or OYA in coordination with the care coordinator. For a MHO Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), Contractor shall also coordinate with such MHO Member's parent or legal guardian.

(1) Integrated Service Array (ISA) for Children and Adolescents

(a) The ISA is a range of service components for children and adolescents, through and including age 17. These services target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings. Contractor shall ensure that the ISA will be recovery focused, family guided, and time limited based on Medically Appropriate criteria.

(b) Contractor shall establish a system that promotes collaboration, within laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families, and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges. Contractor must ensure health care assessments for children and adolescents are conducted within 60 days after being placed under Child Welfare custody.

(c) Contractor shall provide services that are family-driven, strengths-based, culturally and linguistically appropriate, and that enhance and promote quality, community-based service delivery.

(d) Contractor shall use the Child and Adolescent Service Intensity Instrument (CASII) as the statewide tool to assist in the determination for ISA services for children age 6 and older. For children 5 and younger, the statewide tool will be the Early Childhood Service Intensity Instrument (ECSII).

(e) Contractor shall prioritize children with the most serious mental health needs for the ISA who have a mental health diagnosis that is on or above the funded line of the OHP Prioritized List of Health Services. This mental health diagnosis must be the focus of the ISA and the treatment plan. In addition to considering the level of service intensity need indicated by the CASII or ECSII score, Contractor shall take into consideration factors including, but not limited to:

(i) Exceeding usual and customary services in an outpatient setting;

(ii) Multiple agency involvement;

(iii) History of one or more out-of-home placements;

(iv) Significant risk of out-of-home placement;

(v) Frequent or imminent admission to Acute inpatient psychiatric hospitalizations or other intensive treatment services;

(vi) Caregiver stress;

(vii) School disruption due to mental health symptomatology;

(viii) Elevating or significant risk of harm to self or others; and

(ix) For children birth to 5:

(A) History of abuse or neglect;

(B) Conditions interfering with parenting, such as poverty, substance abuse, mental health problems, and domestic violence, and

(C) Significant relationship disturbance between parent(s) and child.

(f) Contractor shall clearly communicate the ISA determination process to MHO Family members, guardians, and community partners, and shall encourage ISA referrals from multiple sources, including families, Allied Agencies, schools, juvenile justice, the faith community and health care providers.

(g) Contractor shall make decisions regarding ISA determinations and referrals to services within three working days consistent with Contractor's policies and procedures.

(h) For MHO Members meeting the determination process outlined in Paragraph (B) above, for intensive treatment services have access to care coordination, Contractor shall have available a child and family team planning process and access to the ISA.

(i) Contractor shall submit written policies and procedures for CASII and ECSII administration and ISA determination processes to AMH's Mental Health Medicaid Policy Unit by February 1st of each year. The policy unit will review the policies and procedures and notify Contractor of its determination of the review and approval within 30 days of receipt.

(j) Contractor shall ensure that Service Coordination will be provided by a person or persons who have a strong child and adolescent mental health background, extensive knowledge of the children's system of care, and experience working with families.

(k) Contractor shall have a child and family team assist in the development of the Service Coordination plan. The team may include the MHO Member child, if appropriate, Family members, child serving agencies involved with the child,

school, culturally specific community based organizations and other community supports identified by the Family.

(l) Contractor shall develop and implement a Community Care Coordination Committee that is a community level planning and decision making body to provide practice-level consultation, identify needed community services and supports, and provide a forum for problem solving to families, ISA providers, child serving agencies, and child and family teams. The Community Care Coordination Committee must have representation of the local system of care that includes Consumer and Family members, child serving providers, child and family advocates, culturally specific community based organizations, and other local stakeholders representative of the local system of care.

(m) Contractor shall serve any MHO Member meeting criteria for the ISA, as described in this section, by a provider certified to provide intensive community based treatment services under OAR 309-032-1500 to 309-032-1565.

(n) Contractor shall adopt policies and procedures describing the admission and discharge criteria for a MHO Member child or adolescent requiring the ISA level of care, with a process that includes the active participation of the Family, Allied Agencies, and other persons involved in the child's care.

(o) Contractor shall report on ISA system clinical outcomes by submitting a completed ISA Children's System Progress Review report, administered upon entry, quarterly and upon exit, while Member receives ISA services. Data shall be reported no later than 30 days after entry into ISA services, every 90 days after the initial report and on exit from ISA services. Data shall be submitted electronically to the following web address: https://apps.state.or.us/cf1/amh/

g. Children's Wraparound Demonstration Project Responsibilities – limited to Contractors participating in the Demonstration Project

In service areas with currently funded Children's Wraparound Demonstration projects, Contractor shall create a system of care by implementing a Children's Wraparound Demonstration Project that includes MHO Members and by providing oversight and, in collaboration with OHA, evaluation.

Contractor shall develop local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

3. Provision of MHO Covered Services

a. Contractor shall provide reimbursement for MHO Covered Services obtained by MHO Members outside its Service Area for as long as MHO Covered Services remain unavailable within its Service Area.

b. Notwithstanding 410-141-0500, (1) (b), Contractor shall provide MHO Covered Services as Medically Appropriate to those DHS Child Welfare children residing inside the Contractor's Service Area and those children whose placement by DHS Child Welfare for Behavioral Rehabilitative Services (BRS) is outside the Contractor's Service Area.

c. Contractor shall provide all MHO Covered Services to MHO Members but may require, except in an emergency, that MHO Members obtain such MHO Covered Services from Contractor or Providers affiliated with Contractor. Contractor shall Adjudicate Valid Claims within 45 calendar days of receipt. Contractor shall ensure that neither OHA nor the MHO Member receiving Services are held liable for any costs or charges related to MHO Covered Services rendered to a Member whether in an emergency or otherwise.

d. Contractor's obligation to pay for MHO Emergency Services that are received from non-Participating Providers is limited to MHO Covered Services that are needed immediately and the time required to reach Contractor or a Participating Provider (or alternatives authorized by Contractor) would have meant substantial risk to the MHO Member's health or safety or the health or safety of another.

e. MHO Covered Services following the provision of MHO Emergency Services are considered to be MHO Emergency Services as long as transfer of the MHO Member to Contractor or a Participating Provider or the designated alternative is precluded because of risk to the MHO Member's health or safety or that of another because transfer would be unreasonable, given the distance involved in the transfer and the nature of the mental health condition.

f. Contractor is responsible for arranging for transportation and transfer of the MHO Member to Contractor's care when it can be done without harmful consequences.

g. Contractor shall pay for MHO Covered Services, in accordance with the Emergency Services prudent layperson standard described in the definitions for "MHO Emergency Services" and "Emergency Medical Condition," as needed to assess an Emergency Situation.

h. Contractor may not prohibit or otherwise restrict a mental Health Care Professional (acting within the lawful scope of practice) from advising or advocating on behalf of a MHO Member for:

(a) the MHO Member's mental health care status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether Contractor provides benefits for the particular type of care or treatment;

(b) any information the MHO Member needs in order to decide among all the relevant treatment options;

(c) the risks, benefits, and consequences of treatment or non-treatment;

(d) the MHO Member's rights to participate in decisions regarding his or her mental health care as cited in 42 CFR 438.102 (a)(1)(iv), including the right to refuse treatment, and to express preferences about future treatment decisions.

i. Contractor shall Provide for a second opinion from a qualified mental Health Care Professional within the Provider Panel, or arrange for the ability of the MHO Member to obtain one outside the Provider Panel, at no cost to the MHO Member.

j. As per 42 CFR 438.102, Contractor is not required to provide coverage or reimburse a counseling or referral Service if Contractor objects to the Service on moral or religious grounds. Contractor shall notify OHA if there are any Services not provided by the Contractor due to

moral or religious reasons or if there is no limitation on Services. Contractor shall provide this notification at least 30 days before the start of a new Contract or implementation of a newly adopted policy. If Contractor has not changed its policy regarding provision of Services since the beginning of the preceding year, it shall so notify OHA by submission of Schedule 8. Contractor shall provide this information to MHO Members within 90 days of any changes to its policy. Contractor shall also make available this same information to Potential MHO Members before and during Enrollment.

4. Services Coordination for Mental Health Services Which are Not MHO Covered Services

Contractor shall assist its MHO Members in gaining access to certain mental health Services that are not MHO Covered Services and that are provided under separate contract with OHA. Services that are not MHO Covered Services include, but are not limited to, the following:

a. Medical Transportation pursuant to rules (OAR 410-136-0020 et. seq.) promulgated by OHA and published in its Medical Transportation Services Guide;

b. Medication;

c. Therapeutic Foster Care reimbursed under HCPCs Code S5145 for Members under 21 years of age;

d. Therapeutic Group Home reimbursed for Members under 21 years of age;

e. Behavioral Rehabilitative Services that are financed through Medicaid and regulated by DHS Child Welfare and OYA;

f. Investigation of Members for Civil Commitment;

g. LTPC as defined for Members 21 years of age and older;

h. PASRR for Members seeking admission to a Nursing Facility;

i. LTPC for Members age 17 and under;

(a) Secure Children's Inpatient program (SCIP)

(b) Secure Adolescent Inpatient Program (SAIP)

(c) Stabilization and Transition Services (STS)

j. Personal Care in Adult Foster Homes for Members 21 years of age and older;

k. Residential Services for Members 21 years of age and older provided in Licensed Community Treatment Programs;

l. Abuse investigations and protective Services as described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765; and

m. Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.

5. MHO Member Notices

Contractor shall make available in all clinics, Participating Provider offices, and other Service locations frequented by MHO Members, information concerning Client Notices, Grievances, Appeals, and Administrative Hearings.

6. Practice Guidelines

Contractor shall adopt practice guidelines, specified in 42 CFR 438.236 (b), (c) and (d), that are based on valid and reliable clinical evidence or a consensus of mental health professionals. These practice guidelines must consider the needs of MHO Members, be adopted in Consultation with Contractor's Participating Providers, and be reviewed and updated periodically as appropriate. Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to MHO Member or MHO Member Representative. Decisions for Utilization Management, MHO Member education, coverage of Services, or other areas to which the guidelines apply, should be consistent with the adopted practice guidelines.

7. Authorization for Services

a. Contractor and subcontractor, if so delegated shall have written policies and procedures for processing requests for initial and continuing authorization of services from a MHO Member or Provider. These procedures shall include mechanisms to ensure consistent application of review criteria for authorization decisions; which would include the consultation with the requesting Provider when appropriate.

b. Decisions made by a Health Care Professional with the appropriate clinical expertise in treating the MHO Member's mental health condition, must be included in any determination to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notification of any adverse decision made must occur in writing and provided to the MHO Member and Provider. Notification to the Provider need not be in writing.

c. For standard Service authorization requests, Contractor and subcontractor, if so delegated, shall provide notice as expeditiously as the MHO Member's mental health condition requires, not to exceed 14 calendar days following receipt of the request for Service, with a possible extension of 14 additional calendar days if the MHO Member or Provider requests extension, or if the Contractor justifies a need for additional information and how the extension is in the MHO Member's interest. If Contractor extends the time frame, Contractor shall give the MHO Member and Provider a written notice of the reason for the decision to extend the timeframe and inform the MHO Member of the right to file a Grievance if he or she disagrees with that decision. When a decision is not reached regarding a Service authorization request within the timeframes specified above, Contractor shall issue a Notice of Action to the Provider and MHO Member, or MHO Member Representative, consistent with Exhibit I, Grievance System.

d. If a MHO Member or Provider requests, or Contractor determines, that following the standard timeframes could seriously jeopardize the MHO Member's life or health or ability to attain, maintain, or regain maximum function, Contractor shall make an expedited Service authorization decision and provide Notice as expeditiously as the MHO Member's mental health condition requires and no later than 3 working days after receipt of the request for Service. Contractor may extend the 3 working day time period by up to 14 calendar days if the MHO Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the MHO Member's interest.

e. Mental health services will be documented in the Client Processing Monitoring System (CPMS) maintained by OHA.