OREGON HEALTH PLAN

Amended and Restated

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # 143115-6

with

Health Share of Oregon

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OREGON HEALTH PLAN

HEALTH PLAN SERVICES CONTRACT

COORDINATED CARE ORGANIZATION

This Health Plan Services Contract, Coordinated Care Organization Contract # 143115-6 ("Contract") is between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA", and

Health Share of Oregon
2121 SW Broadway, Suite 200
Portland, Oregon 97201

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

The Contract, as originally adopted effective January 1, 2014, and as previously amended, is hereby further amended and restated in its entirety. The amendment and restatement of this Contract do not affect its terms and conditions for Work prior to the effective date of this Amended and Restated Contract.

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

Division of Medical Assistance Programs (DMAP)
500 Summer Street NE, E35
Salem, Oregon 97301
Contract Administrator: David Fischer or delegate
Phone: 503-947-5522
Fax: 503-945-5972
Email: david.h.fischer@state.or.us

I. Effective Date and Duration

A. This Amended and Restated Contract is effective January 1, 2016 regardless of the date of signature. This Contract, and the CCO Payment Rates contained herein, is subject to approval by the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). In the event CMS fails to approve the proposed 2016 CCO Payment Rates prior to the Effective Date, OHA shall pay Contractor at the proposed CCO Payment Rates, subject to adjustment upon OHA's receipt of CMS approval or modification of the proposed CCO Payment Rates. Unless extended or terminated earlier in accordance with its terms, this Contract expires on December 31, 2018. Contract termination does not extinguish or prejudice DHS' right to enforce this Contract with respect to any default by Contractor that has not been cured.

B. Contractor shall notify OHA not less than 120 days before the Expiration Date of its intent to not proceed with a Renewal Contract.

II. Contract in its Entirety

A. This Contract consists of this document together with the following exhibits which are attached hereto and incorporated into this Contract by this reference, and the reporting forms described in Subsection B:

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: Delivery System Network Provider and Hospital Adequacy Report Reporting Requirements
Exhibit H: Practitioner Incentive Plan Regulation Guidance
Exhibit I: Grievance System
Exhibit J: Review Tool for CCO Informational Materials and Member Education
Exhibit K: Transformation Plan
Exhibit L: Solvency Plan and Financial Reporting

B. Reporting forms are posted at https://cco.health.oregon.gov/Pages/CCO-Contract-Forms.aspx (the "Contract Reports Web Site"), and are by this reference incorporated into the Contract. OHA may change the Contract Reports Web Site after notice to Contractor. All completed reporting forms must be submitted by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for the reports as designated by the Signature Authorization Form available on the Contract Reports Web Site.

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

D. The following optional Services are either included or not included in this Contract as follows:

Included	Not Included	
X		Benefits and Covered Services for MHO Members Only
X		Children's System of Care Wraparound

E. Contractor's Method for Solvency Plan Financial Reporting under Exhibit L is as follows:

X☐ Method A-OHA Approval

☐ Method B-DCBS Approval

☐ Method C-DCBS Certificate of Authority as a Licensed Insurer

III. Vendor or Sub-Recipient Determination

In accordance with the State Controller's Oregon Accounting Manual, policy 30.40.00.102, 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 Nonprofit Corporation organized under the laws of Oregon.

B. Contractor designates:

Janet Meyer
2121 SW Broadway, Suite 200
Portland, OR 97201
Phone: 503-449-3698
Fax: 503-416-1798
Email: janet@healthshareoregon.org

as the point of contact pursuant to Exhibit D, Section 24 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:

50100	Clackamas County-all zip codes
155000	Multnomah County-all zip codes
85000	Washington County-all zip codes

B. Contractor's maximum Enrollment limit is: 290,100. The maximum Enrollment limit established in this section is expressly subject to such additional Enrollment as may be assigned to Contractor by OHA in Exhibit B, Part 3, Section 6, of this Contract; however, such additional Enrollment does not create a new maximum Enrollment limit.

VI. Interpretation and Administration of Contract

A. OHA has adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract and to ensure Contractor's performance. Contractor shall abide by all applicable laws, Oregon Administrative Rules (OARs), Oregon Revised Statutes (ORS), and the items listed in Subsection C (1-6) of this Section, incorporated and in effect on the Effective Date of this Contract. The provision of services under this Contract, the Contractor and

Subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that is in effect on the Effective Date or come into effect during the term of this Contract.

B. 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 in any other exhibits, schedules or attachments, the document earlier in the Table of Contents controls.

C. 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 on the Effective Date, 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) or other enacted Oregon Laws concerning the OHP.

4. The Oregon Administrative Rules (OAR) promulgated by OHA prior to the effective date of this Contract or subsequent amendments to the Contract, to implement the OHP.

5. The OARs promulgated by the Department of Human Services (DHS), to implement the OHP.

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

D. 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. Contractor shall provide information set forth below. 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 filed with the IRS):
Health Share of Oregon
Street Address: 2121 SW Broadway, Suite 200
City, state, zipcode: Portland, Oregon 97201
Telephone: (503) 416-1460 Facsimile Number: (503) 459-5749
E-mail address: janet@healthshareoregon.org

Is Contractor a nonresident alien, as defined in 26 U.S.C. § 7701(b)(1)?
***(Check one box)*: ☐ YES ☒ NO**

Contractor Proof of Insurance:

All insurance listed must be in effect at the time of provision of services under this Amended and Restated Contract.

Professional Liability Insurance Company: OneBeacon
Policy # MCM-00995-15 Expiration Date: 9/1/2016

Commercial General Liability Insurance Company: CNA
Policy # B5088351738 Expiration Date: 9/1/2016

Auto Insurance Company: CNA
Policy # B5088351738 Expiration Date: 9/1/2016

Workers' Compensation: Does Contractor have any subject workers, as defined in ORS 656.027? *(Check one box):* ☒ YES ☐ NO *If YES, provide the following information:*

Workers' Compensation Insurance Company: SAIF
Policy # 797764 Expiration Date: 4/1/2016

Contractor shall provide proof of Insurance upon request by OHA or OHA designee.

Business Designation: (*Check one box*):

☐ Professional Corporation
☐ Limited Partnership
☐ Limited Liability Partnership
☐ Corporation
☐ Other

☒ Nonprofit Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Partnership

B. Certification. The Contractor acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) the Contractor and that pertains to this Contract or to the project for which the Contract work is being performed. The Contractor certifies that no claim described in the previous sentence is or will be a "False Claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Contractor further acknowledges that in addition to the remedies under this Contract, if it makes (or causes to be made) a False Claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Contractor. Without limiting the generality of the foregoing, by signature on this Contract, the Contractor hereby certifies that:

1. Under penalty of perjury, 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 Chapters 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. To the best of the undersigned's knowledge, Contractor has not discriminated against and will not discriminate against minority, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts;

4. 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;

5. 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: https://www.sam.gov/portal/public/SAM/ or such alternative system required for use by Medicaid programs;

6. 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.

7. Contractor is an independent contractor as defined in ORS 670.600.

C. Contractor is required to provide their Federal Employer Identification Number (FEIN) or Social Security Number (SSN) as applicable to OHA. By Contractor's signature on this Contract, Contractor hereby certifies that the FEIN or SSN provided is true and accurate. If this information changes, Contractor is required to provide OHA with the new FEIN or SSN within 10 days.

VIII. Signatures

CONTRACTOR, BY EXECUTION OF THIS CONTRACT, HEREBY ACKNOWLEDGES THAT CONTRACTOR HAS READ THIS CONTRACT, UNDERSTANDS IT, AND AGREES TO BE BOUND BY ITS TERMS AND CONDITIONS.

CONTRACTOR
By: _____ 11/25/15
Authorized Date

Printed Name: Janet Meyer

Title Chief Executive Officer

OHA - DIVISION OF MEDICAL ASSISTANCE PROGRAMS

By _____ 11-30-15
Rhonda J. Busek, Provider Services Director Date
Printed Name Rhonda Busek

Approved as to Legal Sufficiency:

Electronic approval by: Deanna Laidler, Sr. Assistant Attorney General, Health and Human Services Section, on September 2, 2015; email in Contract file.

Reviewed by OHA Contract Administration:

By _____ 11/30/15
David Fischer, Contract Administrator Date

Exhibit A - Definitions

The order of preference for interpreting conflicting definitions in this Contract is (in descending order of priority):

A. Express definitions in this Exhibit A,
B. Express definitions elsewhere in this Contract,
C. Definitions in the OARs cited in Sections 1 to 3 below, in the order of those Sections.

For purposes of this Contract, in addition to terms defined elsewhere in this Contract, the terms below shall have the following meanings when capitalized. If a term below is used without capitalization in this Contract, then the context determines whether the term is intended to be used with the defined meaning.

1. Terms Defined in OAR 410-141-0000

This Contract incorporates all of the definitions in OAR 410-141-0000, including but not limited to the definitions of:

Coordinated Care Services
CCO Payment
Cold Call Marketing
Community Advisory Council (CAC)
Community Standard
Coordinated Care Organization (CCO)
Corrective Action or Corrective Action Plan
Dental Care Organization (DCO)
Disenrollment
Enrollment
Flexible Services
Global Budget
Health Services
Holistic Care
Intensive Case Management
Marketing
Non-Participating Provider
Participating Provider
Prioritized List of Health Services
Service Area
Treatment Plan

2. Terms defined in OAR 410-120-0000

This Contract incorporates all of the definitions in OAR 410-120-0000, including but not limited to the definitions of:

Abuse
Acute
Addiction and Mental Health Division (AMH)
Aging and People with Disabilities (APD)
Ambulance
Ambulatory Surgical Center (ASC)
American Indian/Alaska Native (AI/AN)
Clinic
Ancillary Services
Area Agency on Aging (AAA)
Automated Voice Response (AVR)
Benefit Package
Behavioral Health
Case Management Services
Children's Health Insurance Program (CHIP)
Citizen/Alien-Waived Emergency Medical (CAWEM)
Claimant
Client
Clinical Record
Contested Case Hearing
Co-Payments
Community Mental Health Program (CMHP)
Condition/Treatment Pair
Cost Effective
Covered Services
Date of Receipt of a Claim
Date of Service
Declaration for Mental Health Treatment
Dental Services
Dentist

Diagnosis Related Group (DRG)
Diagnostic Services
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)
Emergency Department
Emergency Medical Transportation
Evidence-Based Medicine
False Claim
Family Planning Services
Federally Qualified Health Center (FQHC)
Fee-for-Service Provider
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
Institutionalized
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
Medicare Advantage
Medicheck for Children and Teens
National Correct Coding Initiative (NCCI)
National Provider Identification (NPI)
Non-Covered Services
Non-Emergent Medical Transportation (NEMT)
Nurse Practitioner
Nursing Facility
Nursing Services
Occupational Therapy
Ombudsman Services
Oregon Health Authority (OHA)
Oregon Youth Authority (OYA)
Out-of-State Providers
Outpatient Hospital Services
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 Provider (PCP)
Prior Authorization (PA)
Private Duty Nursing Services
Provider
Provider Organization
Public Health Clinic
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
Speech-Language Pathology Services
State Facility
Subparts (of a Provider Organization)
Subrogation Surgical Assistant
Suspension
Termination
Third Party Liability (TPL), Third Party Resource (TPR) or Third party payer
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 this Contract

a. "Action" means:

(1) The denial or limited authorization of a requested 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 Provider Network under any of the following circumstances:

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

(b) The Provider is not part of the Provider 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;

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

(d) 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 Provider Network; or

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

b. "Actuarial Report" is defined in Exhibit C, Section 7.

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

d. **"Advance Directive"** means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated per 42 CFR 438.6(i)(1); 42 CFR 422.128; 42 CFR 489.100. A "health care instruction" means a document executed by a principal to indicate the principal's instructions regarding health care decisions. A "power of attorney for health care" means a power of attorney document that authorizes an attorney-in-fact to make health care decisions for the principal when the principal is incapable. "Incapable" means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending physician, a principal lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available.

e. **"Alternative Payment Methodology"** means a payment other than a fee-for-services payment, used by Contractor as compensation for the provision of integrated and coordinated health care and services. "Alternative Payment Methodology" includes, but is not limited to:

(1) Shared savings arrangements;

(2) Bundled payments; and

(3) Payments based on episodes.

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

g. **"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.

h. **"Automatic reenrollment"** means a re-enrollment of a Member with the Contractor when the Member was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

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

j. **"CCO Payment Rates"** means the rates for CCO Payments to Contractor as set forth in Exhibit C, Attachment 1.

k. **"Capitation Payment"** means the portion of the CCO Payment paid under the Capitation Rates (as described in Exhibit C, Section 7) and excludes case rate payments, maternity case rate, bariatric payments, PCPCH pass-through payments, withholds, or any other payments paid outside the Capitation Rate.

l. **"Certified Traditional Health Workers"** has the same meaning as defined in OAR 410-180-0305.

m. **"Child and Family Team"** means a group of people, chosen by the family and connected to them through natural, community, and formal support relationships, and representatives of child-

serving agencies who are serving the child and family, who will work together to develop and implement the family's plan, address unmet needs, and work toward the family's vision.

n. **"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.

o. **"Claims Adjudication"** means Contractor's final decision to pay claims submitted or deny them after comparing claims to the benefit or coverage requirements.

p. **"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.

q. **"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.

r. **"Cultural Competence"** means 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. 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.

s. **"DSM-V Diagnosis"** means the diagnosis, consistent with the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), resulting from the assessment.

t. **"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.

u. **"Effective Date"** means the date this Amended and Restated Contract becomes effective, as described in Section I.A.

v. **"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.

w. **"Emergency Dental Condition"** has the same meaning as defined in OAR 410-123-1060

x. **"Emergency Medical Condition"** means a physical, mental or dental health 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.

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

z. **"Emergency Services"** means physical, mental or dental 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 Member's discharge from a facility or transfer to another facility.

aa. **"Encounter Data"** means encounter claims data that are required to be submitted to OHA under OAR 410-141-3430.

bb. **"Encounter Pharmacy Data"** means encounter claims data for pharmaceutical services delivered by organizations authorized to provide pharmaceutical prescription services under OAR 410-121-0021 and billed through the National Council for Prescription Drug Programs (NCPDP) standard format utilizing the National Drug Code (NDC) and following the billing requirements in OAR 410-121-0150.

cc. **"Evaluation"** means a psychiatric or psychological Assessment used to determine the need for mental health or Substance Use Disorders services. The Evaluation includes the collection and analysis of pertinent biopsychosocial information through interview, observation, and psychological and neuropsychological testing. The Evaluation concludes with the DSM Five-Axis Diagnosis, prognosis for rehabilitation, and treatment recommendations.

dd. **"Expiration Date" means December 31st of each calendar year during the term of this Contract.**

ee. **"External Quality Review Organization" or "EQRO"** means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358 or both.

ff. **"External Quality Review" or "EQR"** means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that Contractor furnishes to its Members.

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

hh. **"Family Partner"** means an individual who is a biological, adoptive or a "forever" person in the parent role, who has been the primary caregiver of a child with emotional or behavioral challenges.

ii. **"Fidelity"** means the extent to which a program adheres to the evidence based practice model. Fidelity to the Wraparound model means that an organization participates in measuring whether Wraparound is being implemented to Fidelity, and will require, at a minimum, assessing (1) adherence to the core values and principles of Wraparound described in ORS 418.977, (2) whether the basic activities of facilitating a Wraparound process are occurring, and (3) supports at the organizational and system level.

jj. **"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.

kk. **"Habilitation Services"** has the same meaning as defined in OAR 410-172-0010s.

ll. **"Health care-acquired condition"** has the same meaning as defined in 42 CFR 447.26(b).

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

nn. **"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.

oo. **"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 process set forth in Exhibit B, Part 8, Section 9.

pp. **"Learning Collaborative"** means a program in which CCOs, state agencies, and PCPCHs can do the following, as well as other activities that serve Health System Transformation objectives and the purposes of this Contract:

(1) Share information about Quality Improvement;

(2) Share information and best practices about methods to change payment to pay for quality and performance;

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

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

(5) Coordinate efforts to develop and test methods to align financial incentives to support PCPCHs;

(6) Share best practices for maximizing the utilization of PCPCHs 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;

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

(8) Share information and best practices on the use of Flexible Services ; and

(9) Share information and best practices on member engagement, education and communication.

qq. **"Licensed Medical Practitioner (LMP)"** means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:

(1) Physician, Nurse Practitioner, or Physician's Assistant, who is licensed to practice in the State of Oregon, and whose training, experience and competence demonstrate the ability to conduct a Mental Health assessment and provide medication management; or

(2) For ICTS and ITS providers, a board-certified or board-eligible child and adolescent psychiatrist licensed to practice in the State of Oregon per OAR 309-019-0115.

rr. **"Local Mental Health Authority" or "LMHA"** 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.

ss. **"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 in a Residential Treatment Facility for children under age 18 and the individual continues to require a Hospital level of care.

tt. **"Marketing Materials"** has the meaning defined in OAR 410-141-3270.

uu. **"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 Clients);

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

vv. **"Medication Override Procedure"** means the administration of psychotropic medications to a person in an Acute Inpatient Hospital Psychiatric Care setting when the person has refused to consent to the administration of such medications on a voluntary basis.

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

xx. **"Member Representative"** means a person who can make OHP related decisions for a Member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A Member Representative may be, in the following order of priority, a person who is designated as the Member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other Family member as designated by the Member, the Individual Service Plan Team (for Members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a DHS or OHA case manager or other DHS or OHA designee. For Members in the care or custody of DHS Children, Adults, and Families (CAF) or OYA, the Member Representative is DHS or OYA. For Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the Member Representative is his or her parent or legal guardian.

yy. **"Member Months"** means the calculation, obtained from Report L.3.1, which represents Contractor's average number of Members during the quarter, multiplied by the number of months.

zz. **"Mental Health Only (MHO) Covered Service"** (if CCO has elected to provide this 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.

aaa. **"Mental Health Only (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 Member's discharge from a facility or transfer to another facility.

bbb. **"Mental Health Only (MHO) Member"** means an individual enrolled for MHO Covered Services only. An a MHO Member may be either:

(1) An individual who 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) An individual who receives physical health services on a fee-for-service basis but who is eligible for and is enrolled in a CCO for MHO Covered Services only.

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

ccc. **"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.

ddd. **"Mental Health Rehabilitative Services"** means coordinated assessment, therapy, consultation, medication management, skills training and interpretive services.

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

fff. **"Neuropsychiatric Treatment Service" or "NTS"** means four units at the State Facility serving frail elderly persons with mental disorders, head trauma, advanced dementia, or concurrent medical conditions who cannot be served in community programs.

ggg. **"Non-Pharmacy Encounter Data"** means institutional and Dental encounter claims that are required to be submitted to OHA under OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200.

hhh. **"Oregon Integrated and Coordinated Health Care Delivery System"** means the system that makes CCOs accountable for care management and provision of integrated and coordinated health care for each Member, 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.

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

jjj. **"Outreach"** has the meaning defined in OAR 410-141-3270.

kkk. **"Patient-Centered Primary Care Home" or "PCPCH"** means a health care team or clinic as defined in ORS 414.655, which meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

lll. **"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).

mmm. **"Payment"** means a CCO Payment as defined in this Exhibit A or a supplemental payment described in Exhibit B, Part 8.

nnn. **"Personal Care Services"** means services that must be prescribed by a physician or licensed practitioner of the healing arts in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State or designee. The services are provided by an individual who is qualified to provide such services and who is not a legally

responsible relative of the Individual. The services may be furnished in a home or other allowable location. The services meeting this criterion are listed in OAR 410-172-0180.

ooo. **"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 when the Contractor does not respond to a request for pre-approval within one hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Contractor physician is not available for consultation

ppp. **"Potential Member"** means a person who meets the eligibility requirements to enroll in the Oregon Health Plan but has not yet enrolled with a specific CCO.

qqq. **"Previous Contract"** means Contractor's contract with OHA for Coordinated Care Services that expired immediately before the effective date of this Contract.

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

sss. **"Provider Preventable Condition**" has the meaning defined in 42 CFR 447.26(b).

ttt. **"Psychiatric Residential Treatment Service" or "PRTS"** has the same meaning as defined in OAR 410-172-0010.

uuu. **"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 in a Treatment Plan within their scope of practice.

vvv. **"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 DSM Five-Axis 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.

www. **"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.

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

yyy. **"Renewal Contract"** means either: (1) a Rate Amendment described in Exhibit C, Section 11; (2) an amendment extending this term of this Contract; or (3) a successor contract between the parties for Coordinated Care Services effective immediately after the expiration date of this Contract.

zzz. **"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.

aaaa. **"Somatic Mental Health"** means symptoms of physical illness such as tension, fatigue, pain or gastrointestinal distress, with no readily ascertainable medical cause

bbbb. **"Special Health Care Needs"** means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and 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).

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

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

eeee. **"Substance Use Disorders"** means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, or to a toxin exposure. The disorders include substance use disorders, such as substance dependence and substance abuse, and substance-induced disorders, such as substance intoxication, withdrawal, delirium, dementia, and substance-induced psychotic or mood disorder, as defined in DSM-5 criteria.

ffff. **"Substance Use Disorders Provider"** means a practitioner approved by OHA to provide Substance Use Disorders services.

gggg. **"System of Care" (SOC)** means a coordinated network of services and supports, including education, child welfare, public health, primary care, pediatric care, juvenile justice, mental health treatment, substance use treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is culturally and linguistically competent, that is designed to build meaningful partnerships with families and youth in the delivery and management of services and the development of policy and that has a supportive policy and management infrastructure.

hhhh. **"Team Facilitation"** means the process of working with the Child and Family Team in developing a unified plan of care.

iiii. **"Therapeutic Abortion"** for purposes of this Contract means any abortion that does not arise under one of the following situations:

(1) The pregnancy is the result of an act of rape or incest; or

(2) 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.

jjjj. "Traditional Health Worker" has the same meaning as defined in OAR 410-180-0305.

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

llll. "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 being Medically Appropriate. A "Valid Claim" is a "clean claim" as defined in 42 CFR 447.45 (b).

mmmm. "Valid Encounter Data" means Encounter Data that comply with OAR 410-141-3430.

nnnn. "Wraparound" means a definable, team-based planning process involving a Member 0-17 years of age (or Members who continue receiving Wraparound services from 18-25 years of age) and the Member's family that results in a unique set of community services, and services and supports individualized for that Member and family to achieve a set of positive outcomes.

oooo. "Wraparound Care Coordination" means the act of developing and organizing Child and Family Teams to identify strengths and to assess and meet the needs of Members 0–17 (or Members who continue receiving Wraparound services from 18- 25 years of age) with complex behavioral health problems and their families. Wraparound Care Coordination involves:

- Coordinating services such as access to assessments and treatment services;
- Coordinating services across the multitude of systems with which the Member is involved; and
- Coordinating care with child welfare, the juvenile justice system and/or developmental disabilities system to meet placement needs.

pppp. "Young Adult Peer Support" means any person supporting an individual or a Family member of an individual, who has similar life experience, either as a current or former recipient of addictions or mental health services or as a Family member of an individual who is a current or former recipient of addictions or mental health services.

Exhibit B –Statement of Work - Part 1 – Governance and Organizational Relationships

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.

2. Community Advisory Council (CAC)

a. To ensure the health care needs of the members of the community are being addressed, Contractor shall establish a CAC which:

(1) Includes, as a majority of the CAC membership, representatives of the community and of the government of each county served by the Contractor. Consumer members must constitute the greater part of such majority.

(2) Ensures diverse membership, with a specific emphasis on those representing populations who experience health disparities.

(3) Has its membership selected by a committee composed of equal numbers of county representatives from each county served by the Contractor and members of Contractor's governing body.

(4) Meets no less frequently than once every three months. Meetings shall follow requirements as outlined in ORS 414.625 and 414.627.

(5) Posts a report of its meetings and discussions to the Contractor's CCO website and other websites appropriate to keeping the community informed of the CAC's activities. The CAC, the Contractor's governing body or a designee of the CAC or Contractor's governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(6) If the regular CAC meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, holds semiannual meetings that:

(a) Are open to the public and attended by the members of the CAC;

(b) Report on the activities of the Contractor and the CAC;

(c) Provide written reports on the activities of the Contractor; and

(d) Provide the opportunity for the public to provide written or oral comments.

(7) Posts to the Contractor's CCO website contact information for, at a minimum:

(a) The CAC chairperson; and

(b) A member of the CAC or a designated staff member of the Contractor

b. Contractor is not required by OHA to subject meetings of the CAC to ORS 192.610 to 192.710, the Public Meetings Law.

c. Duties of the CAC include, but are not limited to:

(1) Identifying and advocating for preventive care practices to be utilized by the Contractor;

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

(3) Publishing an annual report on the progress of the CHP**.**

3. Clinical Advisory Panel (CAP)

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 CAP. If Contractor convenes a CAP, it will include representation from Behavioral Health, physical health systems, and oral health.

4. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP)

a. The Contractor, through its CAC, shall adopt a CHA and a CHP with responsibilities identified in OAR 410-141-3145 and in compliance with ORS 414.627. To the extent practicable, Contractor shall include in the CHA and CHP a strategy and plan for:

(1) Working with the Early Learning Council, the Youth Development Council, Local Mental Health Authority, oral health care providers, the local public health authority , community based organizations, hospital systems and the school health providers in the Service Area; and

(2) Coordinating the effective and efficient delivery of health care to children and adolescents in the community, as follows:

(a) Base the CHP on research, including research into adverse childhood experiences;

(b) Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system;

(c) Improve the integration of all services provided to meet the needs of children, adolescents, and families; and

(d) Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents;

(3) Including school nurses, school mental health providers, and individuals representing child and adolescent health services in the development of Contractor’s CHP.

b. Contractor, with its CAC, shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities. Contractor shall include in the CHA identification and prioritization of health disparities among Contractor's diverse communities, including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other factors in its Service Areas. Contractor shall include representatives of populations experiencing health disparities in CHA and CHP prioritization.

c. Contractor shall conduct the CHA and CHP so that they are transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHP comply with Section ORS 414.627.

d. The CHA and CHP adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The CHP may include, as applicable:

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

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

(3) Findings on health indicators, including the leading causes of chronic disease, injury and death in the Service Area;

(4) Evaluations of and recommendations for improvement of school based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community;

(5) Focus on primary care, behavioral health and oral health;

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

(7) Description of how the CHA and CHP support the development, implementation, and evaluation of patient-centered primary care approaches;

(8) Description of how the objectives of Health Systems Transformation and Contractor's Transformation Plan, described in Exhibit K, are addressed in the CHA and CHP;

(9) System design issues and solutions;

(10) Outcome and Quality Improvement plans and results;

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

(12) Workforce development approaches and outcomes.

e. The CHP shall identify the findings of the CHA and the method for prioritizing health disparities for remedy. Contractor shall provide a copy of the CHP, and annual progress reports to the CHP, to OHA on or before June 30th of each year. The CHA and CHP must be updated at least every

five years. In addition, the updated CHA and CHP, for the five year update requirement, will be due OHA by June 30, 2019.

f. Contractor shall ensure that the LMHA(s) in the Service Area determine the need for local mental health services, coordinate its local planning with the development of the CHP, and adopt a comprehensive local plan for the delivery of local mental health services for children, families, adults and older adults that describes the methods by which the LMHA will provide those services. OHA, with the Contractor, may require the LMHA to review and revise the local plan periodically as referenced in ORS 414.627.

g. Contractor may utilize CHA and CHP guidance provided by the OHA Transformation Center. Such guidance is available at the following web page: http://www.oregon.gov/OHA/Transformation-Center/Pages/Resources-Transformation.aspx.

5. Innovator Agent and Learning Collaborative

a. OHA will provide an Innovator Agent to the Contractor. The Innovator Agent's roles are to act as a single point of contact between the Contractor and OHA on matters regarding innovation, to facilitate the exchange of information, to work with the Contractor and its CAC, and to work with the Contractor to identify and develop strategies to support Quality Improvement and the adoption of innovations in care.

b. Contractor shall participate in face-to-face meetings of any CCO Learning Collaborative at least monthly, if available.

c. If OHA identifies Contractor as underperforming on access, quality or cost against performance and outcome metrics established under this Contract, Contractor will be required to participate in an intensified learning collaborative intervention.

6. Children's System of Care Steering Committee

a. Contractor shall maintain a SOC Steering Committee within its Service Area that is accountable for the implementation and coordination of the provisions of all services within the SOC.

b. The SOC Steering Committee will develop and approve related policies, shared decision-making regarding funding and resource development, review of project outcomes, and identification of unmet needs in the community that supports the expansion of the service array.

c. The SOC Steering Committee will consist of representatives of the Contractor, its Subcontractors, partner agencies, local service providers funded by DHS, criminal justice and other agencies, young adults, families, and advocacy organizations and relevant cultural representation.

Exhibit B –Statement of Work - Part 2 – Covered and Non-Covered Services

1. Covered Services

Contractor shall provide and pay for Covered Services listed in this Exhibit B, in exchange for the CCO Payment described in Exhibit C.

a. Subject to the provisions of this Contract, 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, including Ancillary Services, contained in OAR 410-141-0520 and as identified, defined and specified in the OHP Administrative Rules.

b. Contractor shall provide the Covered Services, including Diagnostic Services that are necessary and reasonable to diagnose the presenting condition, regardless of whether or not the final diagnosis is covered.

c. Contractor shall make available criteria for Medically Appropriate determinations with respect to Benefit Package for physical health, behavioral health (which includes mental health and Substance Use Disorders), and oral health to any Member, Potential Member or Participating Provider, upon request.

d. 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 410-141-0520.

e. Except as otherwise provided in OAR 410-141-0480, Contractor is not responsible for excluded or limited services as described in OAR 410-141-0500.

f. Before denying treatment for a condition that is below the funding line on the Prioritized List of Health Services for any Member, especially a Member with a disability or Co-morbid Condition, Contractor shall determine whether the Member has a funded Condition/Treatment Pair that would entitle the Member to treatment under OAR 410-141-0480.

g. 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 Chapter 410 Division 124.

h. Contractor is prohibited from paying for organ transplants unless the State Plan, Section 1903(i), provides and the Contractor follows written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members.

i. Contractor is responsible for Covered Services for Fully Dual Eligibles for Medicare and Medicaid. Contractor shall pay for Covered Services for Members who are Fully Dual Eligible in accordance with applicable contractual requirements that include CMS and OHA.

2. 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 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; and

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

c. 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, which includes minimum health record requirements in 42 CFR 456.111 and 42 CFR 456.211 for hospitals and mental hospitals as listed below:

(1) Identification of the Member;

(2) Physician name;

(3) Date of admission, dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 456.172 (mental hospitals) or 456.70 (hospitals).

(4) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals).

(5) Reasons and plan for continued stay if applicable.

(6) Other supporting material the committee believes appropriate to include.

(7) For non-mental hospitals only:

(i) Date of operating room reservation.

(ii) Justification of emergency admission if applicable.

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

3. Authorization or Denial of Covered Services

a. Contractor shall establish written procedures that Contractor follows, and requires Participating Providers and Subcontractors to follow, for the initial and continuing Service Authorization Requests. The procedures 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 physical, mental or oral 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 prohibited by OHP rules or elsewhere in this Contract.

c. Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to mental health or Substance Use Disorders Assessment and Evaluation services. Members may refer themselves to mental health and Substance Use Disorders services available from the Provider Network.

d. Contractor shall ensure the provision of sexual abuse exams without Prior Authorization.

e. 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.

f. 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 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 Member Representative, consistent with Exhibit I, Grievance System.

g. If a Member or Provider suggests, 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, within three Business Days after receipt of the request for service and provide Notice as expeditiously as the Member's health or mental health condition requires. Contractor may extend the three Business Day time period by up to 14 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.

h. 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.

i. Contractor shall ensure the provision of Dental Services, that must be performed in an outpatient Hospital or ASC due to the age, disability, or medical condition of the Member, are coordinated and preauthorized.

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 Health Care 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. Notwithstanding the requirements of Subsection j. of this section, Contractor is not required to provide or reimburse for, or provide coverage of, a counseling or referral service if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide or reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds under this paragraph and such objection is not unlawful discrimination, 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.

(1) 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 submit the policy as follows:

(a) To the OHA Contract Administration Unit annually, no later than January 31st.

(b) To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.

(c) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

(2) Subject to OHA prior approval, Contractor shall furnish such information 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 Service Authorization Request 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.

4. 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. Crisis, Urgent and Emergency Services

(1) Contractor may not require Prior Authorization for Emergency Services nor limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

(2) Contractor shall provide 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, regardless of whether the provider that furnishes the services has a contract with Contractor, as provided for in OAR 410-141-3140.

(4) Contractor is encouraged to establish agreements with Hospitals in its Service Area for the payment of emergency screening exams.

(5) Contractor shall not deny payment for treatment obtained when a Member has an Emergency Medical Condition or Emergency Dental Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition or Emergency Dental Condition.

(6) Contractor shall cover and pay for Post-Stabilization Services as provided for in OAR 410-141-3140 and 42 CFR 438.114. Contractor is financially responsible for Post-Stabilization Services obtained within or outside the Provider Network that are pre-approved by a Participating Provider or other Contractor representative as specified in 42 CFR 438.114(c)(1)(ii)(B). Contractor shall limit charges to members for Post-Stabilization services to an amount no greater than what the Contractor would charge the member for the services obtained within the Provider Network.

(7) Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when the enrollee is discharged. 42CFR 438.114.

(8) Contractor shall cover Post Stabilization Services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains the services within the Contractor's network, when the

Contractor could not be contacted for pre-approval or did not respond to a request for pre-approval within one hour.

(9) A Member who has an Emergency Medical Condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member. The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. Based on this determination, the Contractor will be liable for payment.

(10) Contractor shall not refuse to cover Emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider of the Member's screening and treatment within 10 calendar days of presentation for Emergency services as specified in 42 CFR 438.114(d)(1)(ii).

(11) Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructs the member to seek emergency services. 42CFR438.114.

b. Crisis, Urgent and Emergency Services for Mental Health

Contractor shall establish written policies and procedures and monitoring systems that provide for mental health emergency, 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.

(1) 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

(2) Contractor shall establish written policies and procedures and monitoring system for an emergency response system. The emergency response system must provide an immediate, initial or limited duration response for potential mental health emergency situations or emergency situations that may include mental health conditions, including:

(a) Screening to determine the nature of the situation and the person’s immediate need for Covered Services;

(b) Capacity to conduct the elements of a Mental Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;

(c) Development of a written initial services plan at the conclusion of the Mental Health Assessment;

(d) Provision of Covered Services and Outreach needed to address the urgent or emergency situation; and

(e) Linkage with the public sector crisis services, such as pre-commitment.

(3) The emergency response system must include the necessary array of services to respond to mental health crises, which may include crisis hotline, mobile crisis team, walk-

in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.

c. Emergency Ambulance Transportation

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".

d. Non-Emergent Medical Transportation (NEMT)

Contractor shall pay for coordination and provision of NEMT provided for Members if the Member is eligible for NEMT. Contractor's responsibility and Member eligibility for NEMT is specified in OAR 410-141-3435 through 410-141-3485.

e. Preventive Care

(1) Contractor shall provide preventive services, which are those services promoting physical, oral and mental health or reducing the risk of disease or illness included under OAR 410-120-1210, 410-123-1220, 410-123-1260, 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 Covered Services. To the extent such services are Non-Covered 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 Services provided through any Subcontractors (including, but not limited to, FQHCs, 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.

f. 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 responsible for payment, Case Management, or Record Keeping.

g. Sterilizations and Hysterectomies

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

(2) Contractor shall submit a signed informed consent form to OHA Contract Administration Unit for each Member that received either a hysterectomy or sterilization service as described in Subsection (1) above. 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 Provider must recoup the payment and must change the associated encounter claim 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.

h. 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) Contractor shall notify the Member and the facility of the proposed discharge date from PHEC no later than two full 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.

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

(1) Contractor shall make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf 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 Facility 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.

j. Covered Services for Members Receiving 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 AMH Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site;

(b) The AMH Child and Adolescent Mental Health Specialist will respond to Contractor no more than seven Business Days following the date AMH receives a completed Request for LTPC Determination for Member 17 and Under.

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

(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 applicable AMH Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site.

AMH Adult Mental Health Services Unit will respond to Contractor no more than three Business Days following the date AMH receives a completed Request for LTPC Determination for Member 18-64.

(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-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site.

OCS Team will respond to Contractor no more than three Business Days following the date the OCS Team receives a completed Request for LTPC Determination for Member Requiring Neuropsychiatric Treatment.

(b) A Member is appropriate for LTPC when the Member needs either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State Facility 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 Business Days of the date AMH Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons Age 18 to 64; or

(ii) The date the State Facility -NTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State hospital-NTS; 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 Business 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 OHA Team in managing admissions, discharges and transitions from LTPC for Members who require such care at a State Facility, 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 in the long term neuropsychiatric care at the State Facility, Contractor shall work with the Member to assure timely discharge and transition 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 and transition 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.

k. 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). Over the next two years, AMH will be closing the OPRCS system and replacing it with the Measures and Outcome Tracking System (MOTS).

(3) A Medication Override Procedure is considered a "significant procedure" as defined in OAR 309-033-0610. Contractor may perform a Medication Override Procedure only after the person has been committed, there is good cause as described in OAR 309-033-0640, Involuntary Administration of Significant Procedures to a Committed Person with Good Cause, and the requirements of OAR 309-033-0640 have been met.

l. Adult Mental Health

(1) Contractor shall develop and implement cost-effective, comprehensive, person-centered, individualized, and integrated community-based Adult Mental Health services for Members.

(2) Contractor shall provide oversight, care coordination, transition planning and management of the mental health needs of Members to ensure culturally and linguistically appropriate mental health 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 assess Members with serious and persistent mental illness to determine whether the Member should receive evidence-based Supported Employment Services (SE) or Assertive Community Treatment (ACT using encounter code H0039), and provide those services as agreed to with the Member's engagement and choice. Assessment and SE or ACT services must be provided by Providers that meet OHA qualifications. If Contractor lacks qualified Providers to provide SE or ACT services, Contractor shall consult with OHA and develop a plan to develop additional qualified Providers.

(7) Contractor shall provide oversight, care coordination, transition planning and management for Members 18 years and older receiving Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services in licensed and non-licensed home and community based settings.

(8) Contractor shall provide Utilization Review and utilization management, for Members 18 years and older receiving Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services in licensed and non-licensed home and community based settings.

m. Children's Mental Health

(1) Contractor shall develop and implement cost-effective comprehensive, person-centered, individualized, and integrated community-based Children's Mental Health services for Members, using SOC principles. SOC includes a coordinated network of services and supports, utilizing Child and Family Teams and aligning programs to Fidelity standards for specific Member populations. Child and family mental health and substance use services and supports occur within the context of other child and family serving system's care plans and service recommendations. Coordination with child and family serving entities is necessary to ensure quality of care, family and young adult satisfaction and positive outcomes.

(2) Contractor shall provide care coordination that is family and youth-driven, strengths based and culturally and linguistically appropriate. Care coordination will be continuous throughout programs and levels of care for the highest need, most vulnerable children as they transition in and out of intensive community and facility based programming. Contractor shall ensure care coordination is provided, at a minimum, for members 17 and younger for any of the following situations:

(a) Children engaged in mental health services that have two or more placement disruptions due to emotional and/or behavioral precipitators in less than one year.

(b) Children placed in a correctional facility solely for the purpose of stabilizing a mental health condition.

(c) Children placed out of the CCO catchment area in Behavior Rehabilitation Services programs under the jurisdiction of child welfare.

(3) Child, Family and Young Adult Service Array

(a) Contractor shall maintain an intensive and flexible service continuum for children and youth who are at risk of placement disruption, school failure, criminal involvement, homelessness or other undesirable outcomes due a mental health disorder.

(b) Contractor shall adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Community Based Treatment Services Referrals will be reviewed within 7 Business Days. If the referral results in a change or denial of service, a Notice of Action must be issued to the Member, in accordance with the

provisions of Exhibit I. If Contractor denies a service, a medically appropriate plan of care must be developed to address the behavioral health needs of the Member.

(c) Contractor shall provide services to children and families of sufficient frequency, duration, location, and type that are convenient to the youth and family. Services should be expected to alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to mental health disorders and environmental conditions that may impact the remediation of a mental health disorder.

(d) Contractor shall ensure the availability of service, supports or alternatives 24 hours a day/ 7 days a week to remediate a mental health crisis in a non-emergency department setting.

(e) Contractor shall maintain the availability of family and youth peer supports designed to engage families and young adult.

(f) Contractor shall arrange for the provision of non-health related services, supports and activities that can be expected to improve a mental health condition.

(g) Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA. 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.

(4) The CANS Oregon is a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS Oregon screenings will be provided by staff who have been credentialed by the Praed Foundation for administering the CANS Oregon as found at http://canstraining.com

For any Member who is a child, Contractor shall provide a Child and Adolescent Needs and Strengths Comprehensive Screening (CANS Oregon) and a Mental Health Assessment as follows:

(a) Within 60 days of notification that a Member is entering foster care;

(b) Annually for all Members who rated a "Level of Care" of 1 or higher on the initial CANS and remain in foster care;

(c) Within 60 days of notification of the approval of a request for a CANS re-screen; and

(d) For individuals being served through the Fidelity Wraparound planning process.

(5) Contractor shall report on children receiving psychiatric day treatment services and intensive community based treatment services in the Children's Progress Review System

(CPRS) or other OHA approved analytical reporting service. Contractor shall report on clinical outcomes by submitting a completed Children's System Progress Review administered upon entry, quarterly and upon exit, while Member receives services, psychiatric day treatment (PDTS) and/or intensive community based treatment services. Data shall be reported no later than 30 days after entry into Child, Family and Young Adult Service Array, every 90 days after the initial report and on exit from services. Data shall be submitted electronically to the following web address: https://apps.state.or.us/cf1/amh/ or other approved web address.

n. Wraparound Services

(1) Contractor shall administer enhanced Wraparound services to not less than 205 Members per month. Contractor shall ensure Fidelity Based Wraparound Care Coordination for Members 17 and younger for any of the following situations:

(a) Placement in Secure Adolescent Inpatient Program (SAIP), Secure Children's Inpatient Program (SCIP),

(b) Psychiatric Residential Treatment Services or the Commercial Sexually Exploited Children's residential program funded by AMH.

(c) Children meeting local/regional System of Care Wraparound Initiative entry criteria.

(2) Contractor shall ensure that the ratio of care coordinators to families served is no greater than 1:15.

(3) Contractor shall ensure that core values and principles described in ORS 418.977 are followed in delivering Wraparound services, Wraparound Care Coordination and Team Facilitation.

(4) Contractor shall ensure that SOC Wraparound services include Family Partners and Young Adult Peer Supports, as appropriate. Such Family Partners and Young Adult Peer Supports must have experience navigating the mental/behavioral health, child welfare, or juvenile justice system with a child, and be active participants in the Wraparound process. Parent partners engage and collaborate with systems alongside the family/parent.

(5) Contractor shall maintain a process for community stakeholders to review and prioritize children for the Wraparound planning process.

(6) Contractor shall provide non-health related services, supports and activities that can be expected to improve a member's mental health condition.

(7) Contractor shall establish and maintain a Wraparound policy which includes:

(a) The services and supports a Child and Family Team can select and which services and supports need prior approval of the Contractor/Subcontractors and the Wraparound Steering Committee; and

(b) The process required for the Child and Family Team to obtain approval from the Contractor/Subcontractor and the Wraparound Steering Committee on services and supports that need approval.

(c) Contractor shall submit the Wraparound policy no later than January 30, 2016 that has been approved by its Wraparound Steering Committee, to the OHA Contract Administration Unit for review and approval. OHA will notify Contractor within 30 days of the approval status of the policy. Subsequent submissions will be upon OHA request.

(8) Contractor shall work with OHA identified technical assistance entities to administer a tool to identify, implement, and measure Fidelity of its enhanced Wraparound services to ensure that Team Facilitation and Wraparound Care Coordination are consistent with SOC values and are culturally relevant as described at this location: http://www.tapartnership.org/docs/UpdatingTheSOCConcept2010.pdf

(9) Adherence to the Wraparound model is measured using the Wraparound Fidelity Index and other tools that are part of the Wraparound Fidelity Assessment System (WFAS). Information on Fidelity monitoring tools for Wraparound is available here: http://depts.washington.edu/wrapeval/WFI.html.

(10) Contractor shall report on Wraparound system clinical outcomes by submitting a completed Children Progress Review System (CPRS) report or other OHA approved outcome analytic reporting system. Completed entries will be, administered upon entry, quarterly and upon exit, while Member receives Wraparound services. Data shall be reported no later than 30 days after entry into Wraparound services, every 90 days after the initial report and on exit from Wraparound services. Data shall be submitted electronically to the following web address: https://aix-xweb1p.state.or.us/amh_xweb/amh/.

o. Flexible Service

Contractor may provide Flexible Services for Mental Health and Substance Use Disorder services.

p. Substance Use Disorders

(1) Contractor shall provide Substance Use Disorders services to Members, which include outpatient, intensive outpatient, medication assisted treatment including, Opiate Substitution Services, residential and detoxification treatment services. For purposes of this Contract, OHA rules and criteria applicable to outpatient treatment services are located in OAR Chapter 309 Divisions 18, 19 and 22, the OHA rules and criteria applicable to synthetic opiate treatment services located in OAR Chapter 415 Division 20, and the AMH rules and criteria applicable to detoxification centers located in OAR Chapter 415 Division 50. For technical assistance related to this section of this Contract, the OHA contact will be the Medicaid Substance Use Disorders Specialist.

(2) Contractor shall make decisions about access to Substance Use Disorders services, continued stay, discharges, and referrals based upon OHA 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 Disorders services have the training and background in Substance Use Disorders 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 OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access.

(3) Contractor shall consider each Member's needs and, to the extent appropriate and possible, provide specialized Substance Use Disorders services designed specifically for the following groups as set forth in OHA 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, f) individuals with co-occurring disorders, g) parents accessing residential treatment with an accompanying dependent child(ren), and h) individuals accessing residential treatment with medication assisted therapy.

(4) Consistent with Exhibit B, Part 2, Section 6, Non-Covered Services with Care Coordination, Contractor shall coordinate referral and follow-up of Members to Non-Covered Services. Contractor's employees or Subcontractors providing Substance Use Disorders 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.

(5) Contractor shall where Medically Appropriate provide detoxification in a non-hospital based facility. Facilities or programs providing detoxification services must have a letter of approval or license from OHA.

(6) Contractor shall authorize and pay for at least culturally and linguistically appropriate outpatient Substance Use Disorders services to eligible Members who meet ASAM PPC-2R criteria for residential treatment services, when residential treatment services are not immediately available.

(7) Contractor shall require employees or Subcontractors providing Substance Use Disorders services to provide OHA, within 30 days of admission or discharge, with all information required by OHA's most current data system.

(8) Contractor shall use OHA approved Substance Use Disorders screening tools for prevention, early detection, brief intervention and referral to Substance Use Disorders treatment. Contractor may submit alternative screening tools to the Medicaid Substance Use Disorders Specialist, for review and possible approval. For a list of the OHA approved screening tools, Contractor shall contact the Medicaid Substance Use Disorders Specialist.

(9) Contractor shall make a good faith effort to screen all Members and provide prevention, early detection, brief intervention and referral to Substance Use Disorders 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 Disorders or abuse (as noted in the OHA approved screening tools), or d) when the Member over-utilizes Covered Services.

(10) Contractor shall ensure that individuals or programs have a letter of approval or license from OHA for the Substance Use Disorders 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.

(11) Contractor shall inform all Members using culturally and linguistically appropriate means that Substance Use Disorders outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are included in the Benefit Package consistent with OAR 410-141-3300.

(12) Contractor shall provide covered culturally and linguistically appropriate Substance Use Disorders services for any Member who meets admission criteria for outpatient, intensive outpatient, residential, detoxification and medication assisted treatment including opiate substitution treatment, regardless of prior alcohol/other drug treatment or education.

(13) Contractor shall comply with the following access requirements: Members are seen the same day for emergency Substance Use Disorders treatment care. Members, including pregnant women, are seen within 48 hours for urgent Substance Use Disorders treatment care. Members, including intravenous drug users, are seen within 10 Business Days or the Community Standard for routine Substance Use Disorders treatment care.

(14) 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 Disorders services.

(15) 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.

(16) Contractor shall provide Members with culturally and linguistically appropriate alcohol, tobacco, and other drug abuse prevention/education that reduces Substance Use Disorders 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.

q. MOTS Reporting

Contractor shall ensure that all its providers of mental health services and Substance Use Disorders services, including those for DUII and methadone programs, enroll their Members in the Measures and Outcomes Tracking System (MOTS), formerly known as CPMS, as specified at **http://www.oregon.gov/oha/amh/mots/Pages/index.aspx**.

r. 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 Members 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.

s. Intensive Case Management

(1) Contractor is responsible for Intensive Case Management services. This section sets forth the elements and requirements for Intensive Case Management.

(2) Contractor shall make culturally and linguistically appropriate Intensive Case Management Services available to Members identified as aged, blind, or disabled, Members with Special Health Care Needs, Members who have complex medical needs, high health care needs, multiple chronic conditions or Behavioral Health issues, and for Members with severe and persistent mental illness receiving home and community-based services under the State's 1915(i) State Plan Amendment. Intensive Case Management services may be requested by the Member, the Member 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 Business Day following the request.

(4) Contractor shall periodically inform all Participating Providers of the availability of Intensive Case Management services, provide training for PCPCHs 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 Member 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 all Covered Services to Members who exhibit inappropriate, disruptive, or threatening behaviors in a Practitioner's office or clinic or other health care setting.

t. Tobacco Cessation

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.

u. Breast and Cervical Cancer Program Members

Contractor shall identify a primary treating professional for each Member receiving Covered Services on the basis of Breast and Cervical Cancer eligibility. For purposes of this section, "primary treating professional" means a health care professional responsible for the treatment of the breast or cervical cancer. OHA may monitor encounter data to identify these Members who have ceased receiving treatment services. Contractor shall respond to OHA requests for the treating health professional to confirm whether the Member's course of treatment is complete. Services received as part of the Breast and Cervical Cancer Program are exempt from a copay as stated in OAR 410-120-1230.

v. Dental Services

(1) Contractor shall provide to Members all dental Covered Services within the scope of the Member's Benefit Package of Dental Services, in accordance with OAR Chapter 410 Division 141 applicable to DCOs and with the terms of this Contract.

(2) Contractor shall establish written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that are consistent with OAR 410-141-3220(8). The policies and procedures must describe when treatment of an Emergency Dental Condition or Urgent Care Service should be provided in an ambulatory dental office setting, and when Emergency Dental Services should be provided in a hospital setting.

(a) For routine dental care the Member shall be seen within an average of eight weeks and within 12 weeks or the dental office's community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate. Routine dental treatment or treatment of incipient decay does not constitute emergency care.

(b) For an Emergency Dental Service, the Member must be seen or treated within 24 hours; and for an Urgent Dental Service, the Member must be seen or treated within 72 hours or as indicated in initial screening. The treatment of an Emergency Dental Condition is limited to Covered Services. OHA recognizes that some Non-Covered Services may meet the criteria of treatment for the Emergency Dental Condition, however this Contract does not extend to those Non-Covered Services.

5. Optional Covered Services with Care Coordination

Contractor shall provide the following optional services only if designated in the Contract Document, Part II, Section D:

a. Covered Services for MHO Members; and

b. Children's System of Care Wraparound.

For any such service designated in the Contract Document, Part II, Section D, as not included, Contractor shall provide care coordination.

6. Non-Covered Health Services with Care Coordination

a. Contractor shall coordinate services for each Member who requires health services not covered under the CCO Payment.

b. Contractor shall coordinate health services that are not covered within the Member's Benefit Package.

c. 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) for Members 18 years of age and older;

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

(9) Long Term Psychiatric Care (LTPC) for Members age 17 and under, including:

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

(b) Secure Adolescent Inpatient Program (SAIP), or

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

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

7. Non-Covered Health Services without Care Coordination

Non-Covered Services for which Contractor does not need to provide care coordination include but are not limited to:

a. Physician assisted suicide under the Oregon Death with Dignity Act, ORS 127.800-127.897;

b. Therapeutic abortions;

c. Hospice services for Members who reside in a skilled Nursing Facility;

d. Long term care services excluded from Contractor reimbursement pursuant to ORS 414.631;

e. School-based services that are Covered Services provided in accordance with Individuals with Disabilities Education Act (IDEA) requirements that are reimbursed with the educational services program;

f. Administrative examinations requested or authorized in accordance with OAR 410-130-0230;

g. Services provided to CAWEM recipients or CAWEM Plus-CHIP Prenatal Coverage for CAWEM;

8. Flexible Services

In addition to Covered State Plan Services, Contractor shall include Flexible Services that are consistent with achieving Member wellness and the objectives of an individualized care plan. Flexible Services must be coordinated by the Contractor, and may be in collaboration with the PCPCH or other PCP in the DSN. Flexible Services must be administered in accordance with Contractor's policy, written in collaboration with OHA.

Services covered under this Contract may be substituted with or expanded to include Flexible Services, in compliance with Contractor's policy as written in collaboration with OHA, and agreed to by Contractor, the Member and, as appropriate, the family of the Member, as being an effective alternative.

Contractor shall establish written policies and procedures, as written in collaboration with OHA for administering Flexible Services. The policies and procedures shall enable a Participating Provider to order and supervise the delivery of Flexible Services. Contractor shall submit these policies, as follows:

(1) To the OHA Contract Administration Unit annually no later than October 1st.

(2) To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.

(3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

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, Member Representatives 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 Certified Traditional 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; and

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

2. Member Rights under Medicaid

Contractor shall have written policies regarding the Member rights and responsibilities under Medicaid law specified below and Contractor shall:

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

b. Ensure Members are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that Member has a right to report a complaint of discrimination by contacting the Contractor, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR).

c. Provide notice to Members of Contractor's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A.

d. 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.

e. Make Certified or Qualified Health Care Interpreter 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 free of charge for any language and that written information is available in prevalent non-English languages in Service Area(s) as specified in 42 CFR 438.10(c)(3) . Contractor shall notify its Members how to access oral interpretation and written translation services

f. 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.

g. 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 or to obtain services from Non-Participating Providers if the service or type of provider is not available with the Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Exhibit B, Part 3, Section 6.b.

h. 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, preferred language and ability to understand.

i. 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.

j. 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.

k. Furnish to each of its Members the information specified in 42 CFR 438.10(f)(4), 42 CFR 438.10(f)(6) and 42 CFR 438.10(g), if applicable, as specified in the CFR within 30 days after the Contractor received notice of the Member's Enrollment from OHA or for Members 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.

l. 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.

m. 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.

n. 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.

o. Ensure that each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment, and has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, Substance Use Disorders 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.

p. 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.

q. 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.

r. Notify Members of their responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230.

s. If available, utilize electronic methods of communications with Members, at their request, to provide Member information.

t. Contractor may use electronic communications for purposes described in Subsection s above only if:

(1) The recipient has requested or approved electronic transmittal;

(2) The identical information is available in written form upon request;

(3) The information does not constitute a direct Member notice related to an adverse Action or any portion of the Grievance, Appeals, Contested Case Hearings or any other Member rights or Member protection process;

(4) Language and alternative format accommodations are available; and

(5) All HIPAA requirements are satisfied with respect to personal health information.

3. Provider's Opinion

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.

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, 42 CFR 438.10 and 42 CFR 438.10(e)(2)(i) providing general information to potential Members about:

(1) Basic features of managed care;

(2) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

(3) Contractor's responsibilities for coordination of Member care.

Written notice must be translated for Members who speak prevalent non-English languages, as defined in 42 CFR 438.10 (c), and notices must include language clarifying that oral interpretation is available for all languages and how to access it.

b. Contractor shall develop and provide written informational materials and educational programs as described in OAR 410-141-3280 and OAR 410-141-3300. Contractor shall furnish to each of its Members a Member handbook that contains all of the information 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. 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 days of the Member's effective date of coverage with Contractor, which includes the information provided in Exhibit J.

c. Health education shall include: promotion and maintenance of optimal health status, to include identification of tobacco use, referral for tobacco cessation intervention (e.g., 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 Physician 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, advance directive policies and the provision of Certified or Qualified Health Care Interpreter services including the Participating Provider's offices that have bilingual capacity. Contractor shall furnish to each of its Members a member handbook that contains all of the information specified in Exhibit J, consistent with 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.

f. 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 are 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. The OHA Materials Coordinator will review and approve such materials within two Business Days.

g. 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.

h. Contractor shall ensure the Member handbook reflects information on how Members can report suspected Fraud, Waste and Abuse.

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 410-141-3264, 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 Contract Administration Unit for approval. Contractor shall review its Grievance System policies annually and submit as follows:

(1) To the OHA Contract Administration Unit annually no later than January 31st.

(2) To the OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.

(3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

b. Contractor shall provide to all Providers and Subcontractors, at the time they enter into a subcontract, the following Grievance, Appeal and Contested Case Hearing procedures and timeframes:

(1) The Member's right to a Contested Case Hearing, how to obtain a hearing and representation rules at a hearing;

(2) The Member's right to file Grievances and Appeals and their requirements and timeframes for filing;

(3) The availability of assistance in filing;

(4) The toll-free numbers to file oral Grievances and Appeals;

(5) The Member's right to request continuation of benefits during an Appeal or Contested Case Hearing filing and, if the Contractor's Action is upheld in a Contested Case Hearing, the Member may be liable for the cost of any continued benefits; and

(6) Any State-determined Provider appeal rights to challenge the failure of the organization to cover a service.

6. Enrollment and Disenrollment

a. Enrollment

(1) An individual becomes a Member for purposes of this Contract in accordance with OAR 410-141-3080 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.

(c) For persons who are enrolled on the same day as they are admitted to the residential treatment services, Contractor is responsible for said services.

(d) If the person is enrolled after the first day of admission to the residential treatment services, the person will be disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from the residential treatment services.

(2) The provisions of this section apply to all Enrollment arrangements whether Enrollment is mandatory or voluntary as specified in OAR 410-141-3060. 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 in accordance with 42 USC 1396u-2(4)(D). 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 (4).

(3) Contractor shall not discriminate against individuals eligible to enroll on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual

orientation, marital status, age or disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age or disability.

(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, OHA will apply the Disenrollment rules in OAR 410-141-3080 and 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 CCO 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 Representative, OHA may Disenroll the Member in accordance with OAR 410-141-3080 for the following reasons:

(i) Without cause:

(A) OHP Clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the Member's Enrollment; or

(B) Newly eligible Members may change plans, if another plan is available, within 12 months of their initial plan Enrollment or the date OHA send the member notice of the Enrollment, whichever is later; or

(C) A Member may request Disenrollment at least once every 12 months after initial Enrollment; or

(D) Members who are eligible for both Medicare and Medicaid and Members who are AI/AN beneficiaries may change plans or disenroll to fee-for-service at any time; or

(E) Upon Automatic Re-enrollment (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

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

(ii) With cause:

(A) Members may change plans or disenroll to fee-for-service at any time with cause, as defined in 42 CFR Part 438 and Subsections (B) – (D) of this section; or

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

(C) 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 Provider Network, and the Member's PCP or another Provider determines that receiving the services separately would subject the Member to unnecessary risk; or

(D) 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) Services are not provided in the Member's preferred language;

(III) Services are not provided in a culturally appropriate manner;

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

(V) For Continuity of Care.

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

(a) Is uncooperative or disruptive, except where this is a result of the Member's special needs or disability; or

(b) Commits fraudulent or illegal acts such as permitting the use of his or her OHP Client identification card by another person, altering a prescription, theft or other criminal acts committed in any Provider's or Contractor's premises.

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

(a) Makes a credible threat to cause grievous physical injury, including but not limited to, death to others in the near future, and that significant risk cannot be eliminated by a modification of policies, practices or procedures; or

(b) 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.

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

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

(b) Utilization of health services;

(c) Diminished physical, intellectual, developmental or mental capacity;

(d) Uncooperative or disruptive behavior resulting from the Member's special needs, a disability or any condition that is a direct result of their disability, unless otherwise specified in OHP Administrative Rule; or

(e) Other reasons specified in OAR 410-141-3080.

(7) The effective date of Disenrollment when requested by a Member will be the first of the month following OHA's approval of Disenrollment. 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.

(8) 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 at the time of service, any services the Member received during the period of the retroactive Disenrollment may be eligible for fee-for-service payment under OHA rules.

(9) 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.

(10) Disenrollment required by adjustments in Service Area or Enrollment is governed by Exhibit B, Part 3, Section 6 of this Contract.

c. Member Benefit Package Changes

The weekly and monthly enrollment file (as described in Exhibit B, Part 3, Section 6.d of this Contract) will identify Member's current eligibility status. The file does not include any historical data on Member's eligibility status.

d. Enrollment Reconciliation

(1) Contractor shall reconcile the OHA 834 monthly 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 Enrollment Reconciliation Coordinator via secure email, using the Enrollment Reconciliation Certification Forms, which are available on the Contract Reports Web Site. Contractor's determination of OHA 834 monthly 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", to OHA Enrollment Reconciliation Coordinator within 14 days of receipt of the OHA 834 monthly Enrollment transaction file, or

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

7. Identification Cards

Contractor shall provide an identification card to Members which contains simple, readable and usable information on how to access care in an urgent or emergency situation consistent with OAR 410-141-

3300. Such identification 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 to Potential Members

a. Contractor shall apply the prohibitions of this paragraph to its agents, Subcontractors, and Subcontractor's agents.

b. Contractor and its Subcontractor's communications that express participation in or support for the Contractor by its founding organizations or its Subcontractors shall not constitute an attempt to compel or entice a Potential Member's enrollment

c. Contractor has sole accountability for producing or distributing Marketing Materials following OHA approval.

d. Contractor shall ensure that Potential 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.

e. Contractor shall provide copies of all written Marketing Materials to all DHS and OHA offices within Contractor's Service Area. Pursuant to 42 CFR 438.104(b)(2), Contractor shall make no assertion or statement (whether written or oral) that:

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

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

f. Contractor shall comply with the information requirements of 42 CFR 438.10, 438.100 and 438.104 to ensure that, before enrolling, the Potential Member receives, from the Contractor the accurate oral and written information the Potential Member needs to make an informed decision on whether to enroll with the Contractor. In doing so, the Contractor shall:

(1) Not distribute any Marketing Materials without first obtaining OHA approval;

(2) Distribute the Marketing Materials to its entire Service Area as indicated in this Contract;

(3) Not seek to compel or entice Enrollment in conjunction with the sale of or offering of any private insurance; and

(4) Not directly or indirectly engage in door to door, telephone or Cold Call Marketing activities; and

g. Contractor shall comply with OHA Materials Submission and Approval Form. The form is located at on the Contract Reports Web Site. Submission of the form goes to OHP.Materials@state.or.us.

h. OHA will develop guidelines through a transparent public process, including input from Contractor and other stakeholders. The guidelines will include, but are not limited to:

(1) A list of communication or Outreach Materials subject to review by OHA;

(2) A clear explanation of OHA's process for review and approval of Marketing Materials;

(3) A process for appeals of OHA's edits or denials;

(4) A Marketing Materials submission form to ensure compliance with PHP Marketing rules; and

(5) An update of plan availability information submitted to the OHA on a monthly basis for review and posting.

Exhibit B –Statement of Work - Part 4 – Providers and Delivery System

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 PCPCH.

a. Contractor shall ensure, and shall implement procedures to 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 Disorders 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 CCOs 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.

c. Contractor shall coordinate the services the Contractor furnishes its Members with the services the Member receives from any other MCO, PIHP or PAHP to avoid duplication of services, as required by 42 CFR 438.208 (b) (2).

2. Access to Care

Contractor shall provide culturally and linguistically appropriate services and supports, in locations as geographically close as possible, to where Members reside or seek services and choice of Providers (including physical health, behavioral health, including mental health and Substance Use Disorders, and oral health) 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. Contractor shall make Covered Services available 24 hours a day, 7 days a week, when medically appropriate.

b. As specified in OAR 410-123-1000 through 410-123-1640, for routine dental care the Member shall be seen within an average of eight weeks and within 12 weeks or the dental office's community standard, whichever is less, unless there is a documented special clinical reason which would require longer access time.

c. 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.

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

e. 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 Disorders 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.

f. 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 Disorders, 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 Disorders or mental health specialists for treatment of the Member's condition and identified needs including the assistance available through intensive care coordinators if appropriate.

(3) Contractor shall implement procedures to share with Member's Primary 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. Contractor's procedures shall also require that the Member's assessment information be shared with other prepaid managed care health services organizations serving the Member. Such coordination and sharing of information must be conducted within federal and State laws, rules, and regulations governing confidentiality.

g. 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.

h. 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.

i. 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.

j. 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.

k. 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) and (2).

l. 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 Provider 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.

m. Contractor shall provide female Members with direct access to women's health specialists within the 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.

o. To effectively integrate and coordinate health care and care management for Fully Dual Eligible Members, Contractor shall demonstrate its ability to provide Medicare benefits to Fully Dual Eligible Members. This may be accomplished through a Medicare Advantage plan that is owned by, affiliated with, or contracted by the Contractor.

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 10), and has sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to Covered Services, as required by this Contract and OHA rules, to Members across the age span from child to older adult, including Members who are Fully Dual Eligible. In establishing and maintaining the Provider Panel, Contractor shall consider, at a minimum, the following:

(a) The anticipated Medicaid Enrollment and anticipated Enrollment of Fully Dual Eligible individuals;

(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, also taking into consideration the oral, physical 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 Provider Network is sufficient in numbers and areas of practice and geographically distributed in a manner that the Covered 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;

(h) Contractor's approach to integrated care and care coordination and the use of PCPCHs; and

(i) Contractor shall report on its Delivery System Network (DSN), including an appropriate range of preventive, primary care and specialty services, sufficient in number, mix and geographic distribution to meet Member needs, using Exhibit G.

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

(3) Contractor shall provide Members with access, as Medically Appropriate, to licensed medical professionals, Substance Use Disorder, oral and mental health Providers.

(4) Contractor shall demonstrate that the number of Indian Health Care Providers that are Participating Providers is 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.

(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, including physical health, behavioral health (which includes mental health and Substance Use Disorders), and Dental 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. Non-Participating 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.

(9) Contractor shall demonstrate that the number of Substance Use Disorders residential treatment facilities that are Participating Providers is sufficient to ensure access to Covered Services that meet the specific needs of its Members. Participating Providers shall at least include facilities that can meet cultural and linguistic appropriateness, adolescents, parents with dependent children, pregnant women, IV drug users and Members with medication assisted therapy needs.

b. Provider Selection

Contractor shall establish written policies and procedures in place which comply with the CCO rule for credentialing and recredentialing, OAR 410-141-3120, 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:

(1) Complete the DSN Provider Capacity Report as required in Exhibit G and submit to the OHA Contract Administration Unit an update of this DSN Provider Capacity Report at any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services, including changes in services, benefits, Service Area or payments or the Enrollment of a new population or any time it enters into a contract with OHA;

(2) 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 Provider Network, it must give the affected Providers written notice of the reason for its decision;

(3) Assure that Certified Traditional Health Workers, who are employed by Contractor or subcontractors, have met the requirements for background checks for Certified Traditional Health Workers, as described in OAR 410-180-0326.

(4) Provide a dispute resolution process, including the use of an independent third party arbitrator, for a Provider's refusal to contract with Contractor or the termination, extension or renewal of a Provider's contract with Contractor, pursuant to OAR 410-141-3269.

4. Delivery System Features

Contractor shall ensure that Members have access to high quality, appropriate integration and coordination of 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.

(2) 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.

(3) Ensure that Members of all communities in its 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.

(4) Encourage the use of FQHCs, 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 primary 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 long term care 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 Type B AAAs or State APD district offices in its Service Area for their Members receiving DHS Medicaid-funded long term care services.

(e) Contractor shall document and submit no later than June 30th , an update of coordination activities through Memoranda of Understanding (MOU), or subcontractual arrangement(s) between the Contractor and the Type B AAA or State APD district office(s) in its Service Area. The APD MOU guidance document can be found at http://www.oregon.gov/dhs/pages/hst/apd-cco-info.aspx (will be updated by APD). MOUs will be reviewed by DHS-APD and OHA and feedback will be given to Contractor.

(f) Contractor shall coordinate with residential addictions and mental health services Providers, including Providers outside of Contractor's Service Area, for their Members receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services.

(g) 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 and work with their Providers to develop 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:

(a) Ensure a network of Providers to serve Members' health care, 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 transform 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 its Service Area, 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 Disorders Treatment: Outpatient mental health and Substance Use Disorders treatment shall be integrated into a person-centered care delivery system and coordinated with physical health care services by Contractor and by Contractor's transformed health system.

(2) Oral Health: In accordance with ORS 414.625(5) Contractor shall have a formal contractual relationship with any DCO that serves Members in its 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 primary 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 Certified Traditional Health Workers who may be part of the Member's primary 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 Disorders 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. Contractor shall receive notification of members with high health needs in the eligibility and enrollment data provided the Contractor by the State.

(2) Contractor shall provide intensive care coordination or Case Management Services to Members who are aged, blind, disabled or who have complex medical needs, 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 to 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 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 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 Services 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 Members, Potential Members or Member 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 Contract Administration Unit 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 of eliminating racial and ethnic disparities and meeting national Healthy People 2020 objectives and Meaningful Use standards.

b. Provide culturally and linguistically appropriate health risk assessment for Members. Assessment may be provided or coordinated through a Members' PCPCH. 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 (3rd edition) (2008) for pediatric populations to patients, families, and Providers.

e. Demonstrate evidence of partnership with health promotion, racially, ethnically and linguistically diverse community, 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. (Reserved)

9. Patient Centered Primary Care Homes (PCPCH)

Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes as 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.

a. In addition to Provider reporting requirements described in OARs, Contractor shall provide a report to OHA Contract Administration Unit, no later than 30 days following the end of each quarter, to include all Members 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.

b. 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.

10. Subcontract Requirements

Contractor shall ensure 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 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 (also referred to as agreement to pay) on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

(5) Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

(6) Contractor shall provide every Provider or Subcontractor, at the time it enters into a contract or subcontract its OHA approved written procedures for its Grievance System and ensure compliance.

(7) 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(a)(1). As specific in the aforementioned CFRs, the Contractor shall oversee and be held accountable for any functions or responsibilities it delegates to a subcontractor. 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.

(8) Contractor's written 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 11 and Section 12; and

(d) Require Subcontractor to submit Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from the Provider, and within time frames that assure all corrections have been made within four months of the Date of Service. Contractor and its Subcontractors may, by mutual agreement, establish an alternative payment schedule not to exceed the minimum requirements.

(9) Contractor shall provide Members written notice of termination of any Subcontractor, within 15 Business 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.

(10) 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) Minority-Owned, Woman-Owned and Emerging Small Business ("MWESB") Participation.

(a) As noted in Governor Kitzhaber's Executive Order 12-03: "Minority-owned and Woman-owned businesses continue to be a dynamic and fast-growing sector of the Oregon economy. Oregon is committed to creating an environment that supports the ingenuity and industriousness of Oregon's Minority Business Enterprise [MBE] and Woman Business Enterprise [WBE]. Emerging Small Business [ESB] firms are also an important sector of the state's economy."

(b) Contractor shall take reasonable steps, such as through a quote, bid, proposal, or outreach process, to ensure that MWESB certified firms are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Contract. If there may be opportunities for subcontractors to work on the Contract, it is the expectation of OHA that the Contractor will take reasonable steps to ensure that MWESB certified firms, as referenced on: http://www.oregon4biz.com/how-we-can-help/OMWESB/ ,are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Contract.

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. Contractor shall remain responsible for maintaining sufficient capacity and solvency, and providing all Covered Services through the end of the 90 day period. OHA will not approve a transfer of Members if the Provider's contract with the transferring Contractor is terminated for reasons related to quality of care, competency, Fraud or other reasons described in OAR 410-141-3080. 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.

(1) 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 day notice, less than the required notice to OHA may be provided with the approval of OHA.

(2) 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. Contractor shall remain responsible for providing all Covered 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 its 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 day 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 11, Contractor remains responsible for all Covered 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 up to 20% of Contractor's monthly CCO Payment (subject to actuarial considerations) 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 or the Enrollment limit, or both, OHA may recalculate the CCO Payment rates using the following methodology, as further described in Exhibit C:

If the calculation based on the reduced Service Area or Enrollment limit would result in a rate decrease, OHA may provide Contractor with an amendment to this Contract to reduce the amount of the CCO Payment rates in Exhibit C, Attachment 1, which (subject to CMS approval) will be effective the date of the reduction of the Service Area or Enrollment limit.

g. If this Contract is amended to expand the Service Area or the Enrollment limit, or both, OHA may recalculate the CCO Payment rates using the following methodology, as further described in Exhibit C:

(1) If the calculation based on the expanded Service Area or Enrollment limit would result in a rate increase, OHA may provide Contractor with an amendment to this Contract to increase the amount of the CCO Payment rates in Exhibit C, Attachment 1, which (subject to CMS approval) will be effective the date of the expansion of the Service Area or Enrollment limit.

(2) If the calculation based on the expanded Service Area or Enrollment limit would result in a rate decrease, OHA will provide Contractor with an amendment to this Contract to adjust Contractor's rates when the next OHP-wide rate adjustment occurs.

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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, to the greatest extent possible, for all Members including those receiving mental health and Substance Use Disorder services, 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 gather and utilize additional qualitative data to address the causes of disparities in health care delivery and in health outcomes.

Exhibit B –Statement of Work - Part 6 – Alternative Payment Methodologies

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

Contractor shall implement a schedule of alternative payments, with benchmarks and evaluation points identified that demonstrate direct support for transformation of care delivery and the sustainability of care innovations across the care continuum. Contractor shall assign a high priority to implementing alternative payments and incentives for PCPCHs; such payments and incentives shall provide a sufficient level of financial support necessary to offset costs of PCPCH care transformation, sustain adequate staffing and capital resources necessary to maintain the recognized tier level of PCPCH care, and reward PCPCHs that improve or meet benchmarks on quality and care outcome measures.

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 Rural Type A Hospitals and Rural Type B 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 Exhibit C. 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. In the event that OHA removes the Hospital reimbursement adjustment from the CCO Payment rate, Contractor shall no longer be required to distribute such Hospital reimbursement adjustment amount to eligible Hospitals.

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;

b. Client Process Monitoring System Forms data. Over the next two years, AMH will be closing the CPMS system and replacing it with the Measures and Outcome Tracking System (MOTS).

c. Copies of completed Request for LTPC Determination 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. Covered 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 410-120-1280 and OAR 410-141-3420 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 in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120; and

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

f. Contractor shall provide to OHA, upon request, verification that Members were contacted to confirm that billed services were provided in accordance with 42 CFR 455.20 and 433.116 (e) and (f) by:

(1) Providing a notice, within 45 days of the payment of a claim, to all or a sample group of the Members who received services;

(2) The notice must, based on information from the Contractor's claims payment system, specify:

(i) The services furnished;

(ii) The name of the Provider furnishing the services;

(iii) The date on which the services were furnished; and

(iv) The amount of the payment made by the Member, if any, for the services; and

(3) The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.

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 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 the 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 shall provide, and require its Subcontractors to 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 32 through 36.

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 HIPAA, and complete Clinical Records that document the Covered 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 law including ORS 192.561, 413.171, and 414.679; 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 Participating Providers may charge the Member for reasonable duplication costs when the Member seeks copies of his or her 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 Provider Network 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 its 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, OHA, 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 Covered 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, and shall cause its Participating Providers to 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, and shall cause its Participating Providers to 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 the event of Emergency Services that Members obtain such Covered Services from Contractor or Providers affiliated with Contractor in accordance with OAR 410-141-3420 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, including Holistic Care.

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 PPACA regarding the use of National Correct Coding Initiative (NCCI).

e. Certain federal laws governing reimbursement of FQHCs, 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 FQHCs, 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.

f. Contractor shall prohibit Subcontractors and Providers from billing Members, for Covered Services in any amount greater than would be owed if Contractor provided the services directly, consistent with 42 CFR 438.106 and 42 CFR 438.230.

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 Member 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 30 days of receipt and at least 99% of Valid Claims within 90 days of receipt. Contractors shall make an initial determination on 99% of all claims submitted within 60 days of receipt. The Date of Receipt of a Claim 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 to 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 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 including Indian Tribe, Tribal Organization or Urban Indian Organization, in accordance with FFS timely payment, including paying of 90% of all valid claims from providers, within 30 days of the date of receipt; and paying 99 percent of all clean claims from providers within 90 days of the date of receipt per 42 CFR 447.45 and 42 CFR 447.46.

h. In accordance with Section 5006 of the American Reinvestment and Recovery Act of 2009 (ARRA), Contractor shall not impose fees, premiums or similar charges on Indians served by an Indian health care provider, Indian Health Services (HIS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).

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

Contractor shall not make payment for any Provider Preventable Conditions; OHA will provide guidance summarizing the non-payment of Provider Preventable Conditions. Contractor shall:

(1) Require all Providers to comply with the reporting requirements as a condition of payment from Contractor;

(2) Require all Providers to identify Provider Preventable Conditions that are associated with claims for CCO Payment or with courses of treatment furnished to Members for which CCO Payment would otherwise be available; and

(3) Report all identified Provider Preventable Conditions in a form or frequency as may be specified by OHA; and

(4) Not make payment to Providers for Provider Preventable Conditions that are Health Care-Acquired Conditions or that meet the following criteria as specified in 42 CFR 447.26(b):

(i) Is identified in the State plan.

(ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(iii) Has a negative consequence for the Member.

(iv) Is auditable.

(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a Member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong Member.

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 its 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 coordinate care and benefits that are Covered Services with Medicare payers and Providers as Medically Appropriate for the purpose of achieving appropriate health outcomes for 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.

f. Contractor shall report to the OHA Contract Administration Unit its affiliation or contract with Medicare Advantage Plan entities in Contractor's Service Area(s) using the Affiliated Medicare Advantage Plan Report which is available on the Contract Reports Web Site. Contractor shall update its Affiliated Medicare Advantage Report at any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services, annually no later than January 31 of each year, and upon OHA request.

6. Eligibility Verification for Fully Dual Eligible Members

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 AVR 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 Claims Data

a. Contractor shall submit all Encounter Claims Data to OHA electronically using HIPAA Transactions and Codes Sets or the National Council for Prescription Drug Programs (NCPDP) Standards 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. Contractor shall demonstrate to OHA through proof of enrollment information, 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 following reports to OHA as described in each report.

Encounter Data Certification and Validation Report, and
Encounter Claim Count Verification Acknowledgement and Action Report.
Pharmacy Expense Proprietary Exemption Request Report
Pharmacy Expense Report

The reports are available on the Contract Reports Web Site.

Contractor shall maintain sufficient encounter data to identify the actual provider who delivers services to the Member per SSA section 1903(m)(2)(A)(xi).

d. Encounter Data Submission and Processing

(1) Contractor shall submit valid Encounter Data at least once per calendar month, on forms or formats specified by OHA and in accordance with OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200. The Encounter Data submitted must represent 50 percent of all Encounter claim types received and adjudicated by Contractor during that calendar month, 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 correct errors in 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 any Encounter Data submission cannot be processed because of missing or erroneous information.

(3) To prevent Corrective Action, Contractor may submit documentation to OHA citing specific circumstances that delay Contractor's timely submittal of Valid 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.

8. Encounter Claims Data (Non-Pharmacy)

a. Contractor shall submit all valid unduplicated Non-Pharmacy Encounter Data to OHA within 60 days of the Claims Adjudication date. The Claims Adjudication date is the date of Contractor's payment or denial. Corrective action may be initiated if more than 10% of the Encounter Data submitted are over 60 days after the Claims Adjudication date or if the submissions of duplicate claims exceed 10% per month.

b. Contractor shall correct errors in 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 any Encounter Data submission cannot be processed because of missing or erroneous information.

c. OHA will notify Contractor of the status of all Encounter Data processed. Notification of all Encounter Data that must be corrected will be provided to Contractor each week. Encounter Data on this notification is referred to as "Encounter Data Requiring Correction." OHA will not necessarily notify Contractor of report errors.

d. Contractor shall submit corrections to all Encounter Data Requiring Correction within 63 days of the date OHA sends Contractor notice. Encounter Data Requiring Correction that are not corrected to be Valid Encounter Data within 63 days of OHA notification are subject to Corrective Action.

9. Encounter Pharmacy Data

a. The Encounter Pharmacy Data submitted must represent 50 percent of all pharmacy claim types received and adjudicated by Contractor during that calendar month, 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).

b. Contractor shall submit all valid, accepted liability, unduplicated Encounter Pharmacy Data to OHA within 60 days of the dispense date. Corrective action may be initiated if more than 10% of the Encounter Pharmacy Data submitted are over 60 days after the dispense date or if the submission of duplicate claims exceed 10% per month.

c. Contractor shall correct errors in Encounter Pharmacy Data if the Encounter Pharmacy Data cannot be processed because of missing or erroneous information. Corrective Action may be initiated if more than 10% of any pharmacy data submission cannot be processed because of missing or erroneous information.

d. OHA will notify Contractor of the status of all Encounter Pharmacy Data processed. Notification of all Encounter Pharmacy Data that must be corrected will be provided to Contractor each week. Encounter Pharmacy Data on this notification is referred to as "Pharmacy Data Requiring Correction." OHA will not necessarily notify Contractor of report errors.

10. Administrative Performance Program

a. The Administrative Performance (AP) Standard utilizes the AP Withhold (APW) methodology described in this section. The APW methodology requires the submission of Valid Encounter Data, including pharmacy claims data that is submitted to OHA and certified in accordance with OAR 410-141-3430 and that is also submitted to the All Payer All Claims database by OHA or by Contractor. OHA may provide further instructions about the APW process. The APW process will not alter OHA's authority to administer the encounter data requirements of OAR 410-141-3430 or any other provisions under the Contract.

b. For purposes of the APW methodology and calculations, the following definitions apply:

(1) **"AP Standard"** means the standard for accurate and timely submission of all Valid Claims for a Subject Month within 180 days of the end of the Subject Month and the correction of Encounter Data requiring correction with 63 days of the date of notification, applying the standard in OAR 410-141-3430 in effect for the Subject Month.

(2) **"Administrative Performance Withhold"** (or AP Withhold or APW) means the dollar amount equal to one percent (1%) of the Contractor's adjusted Capitation Payment paid for the Subject Month (including monthly and weekly payments combined for the Subject Month) as described in Exhibit C, Section 11 that will be withheld during the Withhold Month.

(3) **"Final Submission Month"** means six months after the last day of the Subject Month.

(4) **"Subject Month"** means the month in which the Date of Service occurred that is under review for timely and accurate encounter data submission using the AP Standard.

(5) **"Withhold Month"** means the month in which an APW will be applied to a Capitation Payment.

c. Contractor shall submit Valid Encounter Data, including Encounter Pharmacy Data, in accordance with the AP Standard not later than the last day of the Final Submission Month. For purposes of this section, the AP Standard allows for a delay factor that allows for Contractor delay of no more than 5% of non-pharmacy encounter claims for the Subject Month with prior notification to OHA for the following reasons:

(1) Member's failure to give the Provider necessary claim information;

(2) Resolving local or out-of-area Provider claims;

(3) Third Party Resource liability or Medicare coordination;

(4) Member's pregnancy;

(5) Hardware or software modifications to Contractor's health information system;

(6) Unanticipated or justified delay that prevented Contractor timely and accurate submission, with an effective plan for resolution, reported by Contractor to OHA and agreed to in writing by OHA prior to the end of the Final Submission Month.

Documented delays due to OHA recognized system issues preventing timely submission or correction of encounter data, including systems issues preventing timely submission to the All Payer All Claims database, will not count as Contractor delay and do not fall within the 5% calculation.

d. For purposes of the APW methodology, all Valid Encounter Data, including Encounter Pharmacy Data, for a Subject Month must be submitted and accepted by OHA as meeting the AP Standard not later than the end of the Final Submission Month.

e. OHA will send Contractor a Subject Month report within 30 days after the end of the Final Submission Month.

(1) If Contractor's Valid Encounter Data submissions for the Subject Month are complete and meet the AP Standard, OHA will issue a final Subject Month report and no withhold will occur.

(2) If Contractor's Valid Encounter Data submissions for the Subject Month have not met the AP Standard, OHA will provide a proposed Subject Month report. The proposed report will become final for purposes of the APW calculations 15 days after the date of the report, unless OHA receives from Contractor a written notice of appeal for the applicable Subject Month not later than 15 days after the date of the report. The notice of appeal from the Contractor must include written support for the appeal.

(3) Any appeal shall be conducted as an administrative review. The administrative review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that administrative review is the sole avenue for review of Subject Month reports for purposes of APW. The decision on administrative review shall result in a final Subject Month report if an appeal was timely filed.

(4) OHA will rely upon the final report to determine whether the Contractor is subject to an AP Withhold for the Subject Month and the withhold amount.

f. If Contractor is subject to an AP Withhold pursuant to this section, after the conclusion of any appeal or the expiration of time to request an appeal, OHA will notify Contractor of the Withhold Month. In general, the AP Withhold for that Subject Month will be applied to the following calendar month's Capitation Payment.

g. OHA will place AP Withhold amounts not paid to Contractor into an AP pool. The AP pool consists of all AP Withhold amounts that are not distributed to any CCO, for a Subject Month, OHA will distribute the AP pool among CCOs that met the AP Standard for the Subject Month (eligible CCOs), allocated proportionately among eligible CCOs on the basis of Member Month Enrollment during the Subject Month. OHA will make AP pool distributions by separate payment to eligible CCOs after all AP appeals related to the Subject Month have been resolved.

h. 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 reports listed below to OHA as described in each report. The reports are available on the Contract Reports Web Site.

Encounter Data Certification and Validation Report,
Encounter Claim Count Verification Acknowledgement and Action Report,

11. 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 period and up to 24 months from CCO paid date of the encounter, covered by the TPL, or the date Contractor receives notification of TPL. "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. Contractor shall retain those recoveries and report to OHA per (11)(f) of this section.

b. OHA and its subcontractor(s) shall take all reasonable actions to pursue recovery of Third Party Liability for Covered Services not recovered by Contractor, beyond 24 months. Any recoveries by OHA will be reported and utilized in the Rate Development process.

c. Contractor shall develop and implement written policies describing its procedures for Third Party Liability recovery. OHA will 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.

d. Contractor shall submit the policy as follows:

(1) To the OHA Contract Administration Unit annually no later than January 31st or attest to no change using Attestation form on CCO forms page.

(2) To OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.

(3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

(4) Subject to OHA prior approval, Contractor shall furnish such information to:

(a) Potential Members before and during Enrollment; and

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

e. 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.

f. Contractor shall report all Third Party Liability to OHA Contract Administration Unit on the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report, Report L.6 of Exhibit L; alternatively, if Contractor reports to DCBS, it shall report Third Party Liability information to DCBS.

g. 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.

h. Contractor will receive from OHA all Third Party Liability and eligibility information available to OHA, in order to assist in the pursuit of financial recovery, as it pertains to Third Party Liability and Personal Injury Liens.

i. Contractor shall provide documentation about personal injury recovery actions and documentation about personal injury liens to the Personal Injury Liens Unit of OHA's Office of Payment and Recovery's (OPAR), consistent with OAR 461-195-0301 to 461-195-0350.

j. 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.

k. 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 CCO Payments to Contractor for the Member after the effective date of the Disenrollment. Contractor and its Providers may not seek to collect from a Member (or any financially responsible Member Representative) or any Third Party Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

l. 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 Subcontractors.

m. 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 Subcontractors, may be paid.

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

o. 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.

p. 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.

12. 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), 1903(m)(2)(A)(xiii) and section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Covered outpatient drugs dispensed to Members are subject to the same rebate requirements as the OHA is, subject under section 1927, and OHA will collect such rebates from manufacturers , 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 and in 1903(m)(2)(A)(xiii). Contractor shall report to the OHA, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Members and other data as the Secretary determines necessary, 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 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 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 days of receipt of the Invoiced Rebate Dispute.

13. 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 OAR 409-025-0150 as well as under this Contract.

14. 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 Subcontractors to prevent and detect Fraud and Abuse activities as such activities relate to the OHP. These policies, at a minimum, must include:

(1) Administrative and management requirements for Contractor's employees and Subcontractors of written standards of conduct and articulate Contractor's commitment to comply with all applicable federal and State laws;

(2) Risk evaluation to monitor compliance in identified problem areas such as claims, Prior Authorization, service verification, utilization management and quality review;

(3) Member Grievance and Appeal resolution processes protecting the anonymity of complaints and to protect callers from retaliation;

(4) Contractor shall report to the Department of Health and Human Services Office of the Inspector General, any providers, identified during the credentialing process, who are on the excluded lists to include List of Excluded Individuals (LEIE) and Excluded Parties List System (EPLS) also known as SAM(System for Award Management).

(5) Participating Provider credentialing and contracting staff education including provisions addressing the non-employment of sanctioned individuals by Contractor and its Subcontractors;

(6) Corrective Action Plans to prevent potential Fraud and Abuse activities, including systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees or Subcontractors who have violated internal Fraud and Abuse policies or applicable statutes, regulations, federal or State health care requirements;

(7) Designation of a chief compliance officer who reports directly to the CEO and the governing body, and submitting that information annually to the OHA Contract Administrator and other appropriate bodies charged with the responsibility of operating and monitoring the Fraud and Abuse program;

(8) Effective lines of communication between OHA's compliance office and Contractor's employees;

(9) Participating Providers and staff education: effective education and training programs will be provided to the compliance officer and all affected employees and Subcontractors; and

(10) Education and training will be supported by enforcement of standards through well publicized disciplinary guidelines and provisions for internal monitoring and auditing.

Contractor shall include in the employee handbook for the Contractor's employees and in written policies for its Subcontractors, 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 Contract Administration Unit as follows:

(1) To the OHA Contract Administration Unit annually, no later than January 31st. Or attest to no changes since last submission using the Attestation form located on the CCO forms page.

(2) To the OHA Contract Administration Unit upon any significant changes, prior to formal adoption of the policy. OHA will notify Contractor within 30 days of the compliance status of the policy.

(3) To the OHA Contract Administration Unit anytime upon OHA request. OHA will notify Contractor within 30 days of the compliance status of the policy.

c. Referral Policy

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) and OHA/DHS Provider Fraud Unit (PAU). Contractor may also refer cases of suspected Fraud and Abuse to the MFCU or to the OHA/DHS Provider Audit Unit prior to verification.

Contractor shall notify OHA/DHS Provider Audit Unit of all referrals to MFCU.

Contractor shall ensure Member handbook reflects information on how to report fraud, waste and abuse

(1) 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/DHS 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 and OHA/DHS to determine if any Participating Provider contract should be terminated.

(2) 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.

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, above. Contractor shall report to the MFCU and OHA/DHS PAU any other incident found to have characteristics which indicate Fraud or Abuse which Contractor has verified. 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.

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

(a) Number of complaints of Fraud and Abuse made to the OHA/DHS PAU or the Medicaid Fraud Unit that warrant preliminary investigation; and

(b) For each matter that warrants investigation, 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 Fraud or Abuse by a Provider

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 OHA/DHS Provider Audit Unit phone number is (888) 372-8301, address is PO Box 14152, 3406 Cherry Ave NE, Salem, Oregon 97309-9965, and fax is (503) 378-2577.

f. Obligations to Assist the MFCU and OHA

(1) Contractor shall permit the MFCU or OHA/DHS PAU 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/DHS PAU investigator during any investigation of Fraud or Abuse.

(3) In the event that Contractor reports suspected Fraud or Abuse, or learns of an MFCU or OHA/DHS PAU 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 or Abuse at no cost to MFCU or OHA/DHS PAU during an investigation.

g. How to Refer a Case of Fraud or Abuse by a Member

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 OHA/DHS PAU. Contractor shall address suspected Member Fraud and Abuse reports to OHA/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

15. 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. This includes all patients observed in an office setting. Examples of abuse and neglect:

a. Any Provider who hits, slaps, kicks, or otherwise physically abuses;

b. Any Provider who sexually abuses;

c. 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

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

16. Disclosure of Ownership Interest

a. Contractor shall provide disclosures in accordance with 42 CFR 455.100 through 42 CFR 455.106 and, in particular 42 CFR 455.104(b), shall provide information regarding 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 455.104 to 455.106. Such disclosures shall include the following:

(1) Whether any of the persons named in this Section 13 are related to one another as a spouse, parent, child or sibling. In accordance with 42 CFR 455.104(b) disclosures that shall be provided to OHA include the following:

(i) Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.)

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation)

(iv) The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest.

(v) The name, address, date of birth, and Social Security Number of any managing employee of the Contractor

(2) Name any other disclosing entity in which a person named in this Section 14 also has an ownership or controlling interest.

(3) Any person with an ownership or control interest in a Subcontractor with whom the Contractor 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 Contractor and a wholly-owned supplier or between Contractor and a Subcontractor during a 5 year period ending on the date of request.

(4) Any person who has an ownership or controlling interest in the Contractor, or is an agent or managing employee of the Contractor, 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.

b. Any person who has an ownership or controlling interest in the Contractor, or is an agent or managing employee of the Contractor shall submit to the OHA Contract Administration Unit the appropriate disclosures at the following times:

(1) Within at least 90 days prior to any changes in ownership or controlling interest exceeding 5 percent;

(2) Upon request of OHA during re-evaluation of Enrollment processes under 42 CFR 455.414;

(3) Within 35 days after any change in ownership, with equity shares transferred being less than 50%;

(4) When Contractor executes a contract with OHA; and

(5) When Contractor amends the contract with OHA though renewal or extension.

17. Upon renewal or extension of the Contract as specified in 42 CFR 455.104(c)(3)Significant Changes in Ownership-with 50% of Equity Interest Transferred

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 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 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 11 of this Contract governing adjustments in Service Area or Enrollment and Exhibit D, Section 18 "Subcontracts".

e. As a condition precedent to obtaining OHA's approval, Contractor shall provide to OHA Contract Administration Unit 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 CCO 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.

18. 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 (excluding 455.460), 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, whether by insurance or a program of self-insurance.

b. Contractors shall ensure Telemedicine credentialing requirements are consistent with OAR 410-130-0610.

c. 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.

d. 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 Provider 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.

e. 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.

f. 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.

g. 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 employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and in accordance with 42 CFR 438.214(d). 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.

h. Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) in the following:

i. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, and when the person furnishing such item or service knew, or had reason to know, of the exclusion

(after a reasonable time period after reasonable notice has been furnished to the person), as stated in section 1903(i)(2)(B) of the Social Security Act.

ii. Furnished by an individual or entity to which OHA has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless OHA determines there is good cause not to suspend such payment, as stated in section 1903(i)(2)(C) of the Social Security Act.

iii. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997, as stated in section 1903(i)(16) of the Social Security Act.

iv. For home health care services provided by an agency organization, unless the agency provides OHA with the surety bond specified in Section 1861(o)(7) of the Social Security Act, as stated in section 1903(i)(18) of the Social Security Act.

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

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

k. Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the delivery of Covered Services, applicable administrative rules, and the Contractor's administrative policies.

19. 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, DMEPOS, or other products. Nothing in this provision prevents Oregon from working with the Contractor and releasing its right to subrogation in a particular case.

Exhibit B –Statement of Work - Part 9 – Quality Performance Outcomes and Accountability

1. Overview

Improving access and quality while reducing the growth rate of per capita costs are key components of Health System Transformation, and measurement is necessary to determine whether the goal of advancing the Triple Aim is met. To this end, initial and ongoing data collection, analysis, and follow up action are required of Contractor.

2. Quality Assurance and Performance Improvement Program Requirements

a. Contractor shall develop and operate a Quality Assurance and Performance Improvement Program (QAPI) for the services it furnishes to its Members in accordance with 42 CFR 438.240 under an annual quality strategy and work plan. The annual quality strategy identifies the goals, objectives and intended outcomes for the annual QAPI program, setting the structure for and guiding the work plan. The work plan flows from the strategic plan and identifies each project and the goal of the project with enough detail to demonstrate its connection to a quality strategy and its performance improvement.

b. Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its systems interventions of its QAPI program. The quality strategy, work plan and QAPI program evaluation must be reported to OHA by January 31 of each year.

c. Contractor shall include Subsections (1) through (9) of paragraph d. below, in the annual QAPI program evaluation; however, these are not intended to be the only QAPI activities reported. Contractor shall include in its annual QAPI program evaluation all system activities utilized to implement and ensure quality coordinated health care, including behavioral health and dental care.

d. Contractor shall include in the annual QAPI program evaluation:

(1) An internal Quality Improvement Committee that monitors the annual quality strategy and work plan;

(2) 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 under-utilization and over-utilization of services, to document the findings, to report aggregate data indicating the number of enrollees identified, and to describe follow-up actions for both findings;

(3) An assessment of the quality and appropriateness of care furnished to all Members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance;

(4) An assessment of the quality and appropriateness of care furnished to Members with special health care needs, with a report of aggregate data indicating the number of enrollees identified and methods used to evaluate the need for direct access to specialists;

(5) A demonstration of improvement in an area of poor performance in care coordination for Members with serious and persistent mental illness, with a report of aggregate data indicating the number of Members identified and methods used;

(6) A report on the grievance system inclusive of complaints, notice of actions, appeals and hearings, and a

(7) Monitoring and enforcement of consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System that ensures consistent response to complaints of violations of consumer rights and protections;

(8) Assessment of the quality of the fraud, waste and abuse program, including the number of preliminary investigations, and the number of referrals to OPAR or MFCU, training and education for employees, CCO Compliance Officer, other CCOs, and Subcontractors; and

(9) Participation as a member of the OHA Quality and Health Outcomes Committee (QHOC).

3. 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.

In accordance with schedules established for performance measures, 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;

4. Performance Measurement and Reporting Requirements

Contractor shall plan for and implement the necessary organizational infrastructure to address performance standards established for this Contract, as follows:

a. "Reporting Year" shall be the calendar year, January 1 through December 31.

b. In each Reporting Year, Contractor is accountable for timely, complete and accurate submission and reporting of encounter data.

c. Performance relative to targets affects Contractor's eligibility for financial and non-financial rewards.

d. OHA's Metrics and Scoring Committee will revise and adopt measures, benchmarks and improvement targets that will apply to the quality incentive program. To the greatest extent possible, measures will be based on national standards.

e. Timely reporting serves as the basis for holding Contractor accountable to contractual expectations. OHA will assess Contractor 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 as part of these assessments.

f. The performance measures reporting requirements will measure the quality of health care and services, during a time period in which Contractor was providing Covered 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 or modification of this Contract or a modification or reduction of the Enrollment or Service Area.

g. Contractor shall include any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets.

h. Metrics that are applicable to this Contract for the time period from the effective date of this Contract through June 30, 2016 are found at http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx.

i. By December 1 of each Reporting Year, OHA will issue the general parameters of the Quality Incentive measures and the structure of the Quality Pool described in Section 9 of this Exhibit B, Part 9, to be implemented for the subsequent year which forms the basis for awarding the Quality Pool in the year following the Reporting Year.

5. Quality Performance Improvement Projects

a. Contractor shall have an ongoing program of performance improvement projects 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. Contractor's ongoing program of quality 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. Contractor shall commit to improving care in at least 4 of the following 7 focus areas. Contractor shall participate in focus area (4), below, as a statewide PIP. Contractor shall select an additional 2 projects from the list below, to serve as the Contractor's Performance Improvement Projects in accordance with 42 CFR 438.358 and 438.240(a)(2). CMS, in consultation with OHA and other stakeholders may specify performance measures and topics for performance improvement projects to be required by OHA in this Contract. Contractor's selected focus areas should align with the quality and incentive requirements for CCOs issued by OHA in December 2012 and the Contractor's Transformation Plan to the extent feasible.

(1) Reducing preventable re-hospitalizations.

(2) Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including Certified Traditional Health Workers, Traditional Health Workers, public health services, and aligned federal and state programs.

(3) Deploying primary care teams to improve care and reduce preventable or unnecessarily costly utilization by "super-users."

(4) STATEWIDE PIP: Integrating primary care and behavioral care.

(5) Ensuring appropriate care is delivered in appropriate settings.

(6) Improving perinatal and maternity care.

(7) Improving primary care for all populations through increased adoption of the PCPCH model of care throughout the Contractor's network.

c. 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 reporting year, as defined in this Exhibit B, Part 9.

d. Contractor must report the status and results of each project to OHA as requested.

6. Program Requirements

If Contractor reports to DCBS for financial solvency matters, 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 438.358 Subpart E, Contractor shall cooperate and shall require its Subcontractors and Providers to cooperate with OHA 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.

c. Consistent with 42 CFR 438.358, OHA will:

(1) Prepare an EQRO protocol and provide to Contractor, prior to review conducted of Contractor, and EQRO follows that protocol;

(2) Provide information previously received from Contractor to the EQRO in an effort to reducing Contractor's duplicative submissions;

(3) Require EQRO to meet competency and independence requirement spelled out in 42 CFR 438.354; and

(4) Require an EQRO to produce the report and information required by 42 CFR 438.364 and to promptly provide such information to Contractor when complete.

d. EQRO review will be limited to mandatory CMS protocols and Information System Capabilities Assessment (ISCA).

8. Monitoring and Compliance Review

a. The parties intend to work together to monitor Contractor's progress. Initially, monitoring and oversight will be aligned with review of progress on the Transformation Plan and related quality strategy and work plan.

b. Upon identification of performance issues, indications that quality, access or expenditure management goals are being compromised, deficiencies, or issues that affect Member rights or health, OHA shall promptly intervene within 30 days of identifying a concern to remediate the identified issue(s) and establish care improvements. Such remediation could include additional analysis of underlying data and gathering supplementary data to identify causes and trends, followed closely by interventions that are targeted to improve outcomes in the problem areas defined. Interventions may include but are not limited to focused Learning Collaboratives, innovator agents, or targeting underlying issues affecting outcomes, performance, access, and cost.

c. If the interventions undertaken in subparagraph (b) of this section do not result in improved performance in identified areas of concern within 90 days, the state may require the CCO to intensify the rapid cycle improvement process. Subsequent actions may include Corrective Action Plans. OHA must inform CMS if Contractor is placed on a Corrective Action Plan or is at risk of sanction, and report on the effectiveness of its remediation efforts. CCOs may be corrected through the Learning Collaboratives and peer-support to the extent practicable.

d. OHA will monitor Contractor's performance, trends and emerging issues on a monthly basis and provide reports to CMS quarterly. OHA must report to CMS any issues impacting the Contractor's ability to meet the access, performance and quality goals of the Contract, or any negative impacts to Member access, quality of care or Member rights.

9. Quality Pool

a. OHA has implemented a Quality Pool, based the outcome and quality measures adopted by the Metrics and Scoring Committee. The Quality Pool is a payment mechanism that rewards all participating CCOs that demonstrate quality of care provided to their Members as measured by their performance or improvement on the outcome and quality measures. The whole Quality Pool is at risk for performance. Total quality payments in the aggregate by OHA are subject to a maximum annual amount. The Quality Pool process will not alter OHA's authority to administer the Encounter Data and quality reporting requirements or any other provisions under the Contract.

b. Contractor will receive a monetary incentive payment from the Quality Pool based on its measured performance or improvement in a calendar year, based on final measure specification

approved by the Metrics & Scoring Committee for the Reporting Year. OHA will publish further instructions about the methodology for distributions from the Quality Pool (the "Reference Instructions") along with the other information described in this section. The final measure specifications and the Reference Instructions for Measurement Years will be published at: http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx

c. Definitions

(1) **"Baseline Year"** means the calendar year for which the Incentive Measures for a Measurement Year are compared.

(2) **"Baseline"** for each Incentive Measure means Contractor's baseline measurement for the Incentive Measure for the Baseline Year.

(3) **"Benchmark"** for each Incentive Measure means the statewide benchmark published at http://www.oregon.gov/oha/analytics/pages/cco-baseline-datafor the Incentive Measure for the Measurement Year, subject to change by the Metrics and Scoring Committee.

(4) **"Distribution Year"** means the calendar year following the Measurement Year.

(5) **"Improvement Target"** for an Incentive Measure means the amount (determined by the methodology set forth in the Reference Instructions and Improvement Targets document online at http://www.oregon.gov/oha/analytics/pages/cco-baseline-data by which Contractor's performance on each Incentive Measure is to improve during the Measurement Year by comparison with the Baseline.

(6) **"Incentive Measures"** means the quality measures specified by OHA for a Measurement Year, subject to change by the Metrics and Scoring Committee and CMS approval.

(7) **"Measurement Year"** means the preceding calendar year.

(8) **"Quality Pool"** means dollar amounts that OHA will pay CCOs as incentives for performance on Incentive Measures, in addition to Capitated Payments.

d. Aggregate Amount

(1) The Quality Pool in aggregate among all CCOs for a Measurement Year will be at least the sum of 2 percent of the aggregate of CCO Payments made to all CCOs for the Measurement Year paid through March 31 of the Distribution Year, excluding any Quality Pool payments made relating to the prior year. Final determination of the Quality Pool size will be published in the Reference Instructions.

(2) The entire Quality Pool will be disbursed annually to CCOs by June 30 of the Distribution Year.

(3) The aggregate amount in the Quality Pool is expected to increase annually. The amount of annual increase will be determined by OHA, subject to CMS approval.

e. Metrics

(1) For the second Measurement Year (CY 2015), CCO performance is based on 17 Incentive Measures, specified at http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx Measure specifications and methodology for the second Measurement Year (CY2014) are documented at http://www/oregon.gov/oha/analytics/pages/cco-baseline-data.aspx.

(2) The number and description of the Incentive Measures, their specifications and operationalization, and which Incentive Measures are tied to the Quality Pool, are subject to change for future Measurement Years, at the discretion of the Metrics & Scoring Committee and subject to CMS approval.

f. Performance

(1) CCOs will be rewarded for meeting the Incentive Measures. The Quality Pool will impose no penalties related to performance.

(2) Each Incentive Measure has certain criteria that Contractor must meet to receive the portion of the Quality Pool payment associated with that Incentive Measure. OHA has published a reference document with all applicable criteria located at http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx.

(3) For each Measurement Year, except as OHA specifies a different method of scoring, Contractor will be measured against the Incentive Measure on a pass or fail basis, and Contractor will pass an Incentive Measure if it meets either the Benchmark or the Improvement Target. For certain Incentive Measures, OHA may specify scoring on a tiered basis or on the basis of ability to report clinical data.

g. Distributions

(1) Quality Pool distributions for a Distribution Year will be made in two stages: Stage 1 and Stage 2.

(2) In Stage 1, Contractor may earn the greater of (a) at least 2 percent of the aggregate of the CCO Payments paid to Contractor during the Measurement Year, or (b) one million dollars. Contractor's award in Stage 1 will be based on its scores for all Incentive Measures.

(3) In Stage 2, CCOs may receive shares of the Quality Pool for the Distribution Year that were not distributed in Stage 1. Contractor will be eligible for a Stage 2 award if it passes specified Incentive Measures.

(4) OHA's reference document specifies details of how the Stage 1 and Stage 2 awards will be computed.

h. Data and Reporting

(1) OHA is responsible for calculating, producing, and validating Contractor's performance on each of the Incentive Measures.

(2) Contractor is responsible for:

(a) Timely and accurate submission of claims, encounter, PCPCH enrollment, and clinical data including medical record data to support hybrid measures and electronic medical record data for three clinical measures per requirements of this Contract; and

(b) Submission of an OHA-approved year three data proposal for the three clinical measures (depression screening, diabetes control, and hypertension).

(3) The performance of Contractor and all other CCOs for each Measurement Year will be based on claims and data for Dates of Service within the Measurement Year submitted to OHA through March 31 of the Distribution Year. Claims and data for Dates of Service in a Measurement Year submitted to OHA after March 31 of the Distribution Year will not be included in the Incentive Measure calculation.

(4) OHA will provide Contractor with its final Incentive Measure calculations for review no later than April 30 of the Distribution Year. Contractor will have until May 30 of the Distribution Year to review and comment on final Incentive Measure calculations for the preceding Measurement Year.

i. Contractor shall offer correlative arrangements with Participating Providers, providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives. Contractor shall report these arrangements and amounts paid to OHA annually, on Exhibit L and submitted in conjunction with the 4th Quarter reporting period (See Exhibit L).

j. Prior Measurement Years data are available online at http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx.

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 Attachment 1 to this Exhibit C, 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 438.700 et seq.

b. The monthly CCO Payment may include risk adjustment based on diagnosis or health status and will include a risk corridor for the special needs rate group in accordance with Section 6 of this Exhibit C.

c. The Covered Services described in Exhibit B, Part 2, have been divided into categories of services. Categories of service in this section describe but do not replace or supersede the scope of Covered Services described in Exhibit B, Part 2. Categories of services are used to develop CCO Payment Rates as described in Exhibit C, Attachment 1.

(1) Mandatory Categories of Services.

For purposes of developing CCO Payment Rates, the following service categories constitute the mandatory categories of Covered Services for Members:

Dental Services
Diagnostic Services/Lab/X-Ray;
DMEPOS/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;
Intensive Outpatient – Substance Use Disorder Treatment
Substance Use Disorder Treatment;
Maternity Case Management (not including Public Health oriented programs);
Mental Health-Acute Inpatient - Inpatient Psychiatric Treatment;
Mental Health-Outpatient Other - Outpatient hospital based;
Mental Health- Alternative to Inpatient - Inpatient sub-acute;
Mental Health- Assessment/Evaluation - Initial Mental Health Assessment or screening;
Mental Health- Case Management:
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 mental Health Members;
Mental Health-Outreach - Most all 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;
Methadone dosing and dispensing;
Opioid Substitution Treatment;
Outpatient Hospital/ASC - Basic includes Emergency Department;
Outpatient Hospital/ASC - Family Planning;
Outpatient Hospital/ASC – Maternity;
Outpatient Hospital/ASC – Sterilization;
Outpatient Hospital/ASC – Hysterectomy;
Outpatient Treatment Services;
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;
Residential Detoxification;
Substance Use Disorders Services;
Tobacco Cessation;
Transportation – Ambulance; and
Vision Exams, Therapy, Materials

For specific details on OHA's end of the month deadline and Enrollment dates schedule Contractor should contact its OHA CCO Account Representative.

(2) Optional Categories of Service

For purposes of developing CCO Payment Rates, the optional categories of Covered Services are found in the Contract Document, Part II, Section D.

d. In addition to the base CCO Payment rate paid to Contractor, OHA will pay a Hospital reimbursement adjustment (Base HRA Adjustment), HRA Administrative Allowance (Hospital Administrative Allowance) and CCO HRA Administrative Allowance (CCO HRA Administrative Allowance) as part of the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in Attachment 1 of this Exhibit C. Upon CMS approval of OHA's Hospital Access to Care Program (HACP) waiver amendment request, the Base HRA Adjustment, Hospital Administrative Allowance and CCO HRA Administrative Allowance will be removed from the rates.

e. As described in OAR 410-141-3420(10)-(12), OHA may require Contractor to continue to reimburse a Rural Type A Hospital or Rural Type B Hospital for the cost of Covered Services based on a Cost-to-Charge Ratio. This section does not prohibit Contractor and a Hospital from mutually agreeing to reimbursement arrangements.

f. 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.

In addition to the base CCO Payment rate paid to Contractor, OHA will pay a Hospital reimbursement adjustment (Base HRA Adjustment), HRA Administrative Allowance (Hospital Administrative Allowance) and CCO HRA Administrative Allowance (CCO HRA Administrative Allowance) as part of the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in Attachment 1 of this Exhibit C. Upon CMS approval of OHA's Hospital Access to Care Program (HACP) waiver amendment request, the Base HRA Adjustment, Hospital Administrative Allowance and CCO HRA Administrative Allowance will be removed from the rates.

2. Payment in Full

The consideration described in this Exhibit C is the total consideration payable to Contractor for all work performed under this Contract. OHA shall ensure that no payment is made to a provider other than the Contractor for services available under the Contract between OHA and the Contractor, except when these payments are specifically provided for in Title XIX of the Social Security Act.

3. Changes in Payment Rates

The CCO Payment Rates may be changed only by amendment to this Contract pursuant to Exhibit D, Section 20 of this Contract.

a. Changes in the CCO Payment Rates as a result of adjustments to the Service Area or to the Enrollment limit may be required pursuant to Exhibit B, Part 4, Section 11 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 414.690, the Prioritized List of Health Services of Condition/Treatment Pairs developed by the Health Evidence Review Commission may be expanded, limited or otherwise changed. Pursuant to ORS 414.690 and 414.735, the funding line for the services on the Prioritized List of Health Services may be changed by the Legislature.

(2) In the event that insufficient resources are available during the term of this Contract, ORS 414.735 provides that reimbursement shall be adjusted by eliminating services in the order of priority recommended by the Health Evidence Review Commission, 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 the term of this Contract will be referred to the actuary who is under contract with OHA for the determination of CCO Payment 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 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 Rates 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 Rates 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.

c. This paragraph applies to any change to the CCO Payment Rates made by a Contract amendment that has retroactive effect or that cannot be implemented before the next regularly scheduled date for payment. If such change increases the CCO Payment owed by OHA to Contractor, then OHA will make a payment to Contractor, by one-time adjustment to a future regularly scheduled Capitation Payment or by separate payment. If such change decreases the CCO Payment owed by OHA to Contractor, then such decrease will be subject to the provisions of this Contract governing overpayments.

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 in the weekly/monthly 820 Group Premium Payment (Capitation) Transaction and in the weekly 835 Payment/Remittance Advice Transaction. To assist Contractor with Enrollment and CCO Payment/Remittance Advice reconciliation, OHA will include in the weekly/monthly 820 Group Premium Payment (Capitation) 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 CCO 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 Covered Services provided to a Member or for any health care services provided to fee for service Clients are not entitled to be paid as CCO 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 under Paragraph f. below.

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 11, 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 may be recovered by OHA from Contractor.

e. Sanctions imposed that result in Recovery Amounts pursuant to Exhibit D, Section 33 through 36 of this Contract are subject to recovery and may be recovered by OHA from Contractor.

f. Any overpayment or Recovery Amount under Exhibit B or C 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 2, Section 4(g), 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 period 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 period the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of Exhibit B, Part 2, Section 4(g), 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 5, Subsection g, of this Contract.

(7) The final results of the review will be conveyed to Contractor in a timely manner within 90 days of determination.

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.

6. CCO Risk Corridor

a. Definitions

The following definitions apply solely within this Exhibit C, Section 6.

(1) **"CCO Risk Corridor"** means a risk sharing mechanism in which OHA and Contractor share in both higher and lower than adjusted expenses under the Contract outside of the predetermined target amount, so that if Contractor's adjusted expenses are outside the corridor in which the Contractor is responsible for all its adjusted expenses, the OHA contributes a portion toward additional adjusted expenses, or receives a portion of lower adjusted expenses.

(2) **"Adjusted expenses"** means priced encounters less offsets during the risk corridor period for SNRG members, divided by the number of SNRG Member Months.

(3) **"Charge"** means the flow of funds from the Contractor to the OHA.

(4) **"Offsets"** means amounts that are not included in the CCO Payment from OHA but that are received from other sources in relation to allowable expenses covered by this Risk Corridor. Offsets include but are not limited to third party resources, Medicare, reinsurance (if any), or other funds or services that resulted in reduction of expenses for the SNRG Members. Offsets are calculated on an accrual basis.

(5) **"Payment"** means the flow of funds from OHA to Contractor.

(6) **"Priced encounters"** means all encounters for covered contracted services (including physical health, mental health, dental and pharmacy) priced using Medicare pricing or other alternatives consistent with state statutes, rules and policies, in accordance with instructions in the SNRG settlement report.

(7) **"Risk Corridor Period"** means January 1, 2015 through December 31, 2015.

(8) **"SNRG Members"** means Members enrolled with Contractor in the special needs risk groups listed below.

(a) Breast and Cervical Cancer Program: Any Member with a program eligibility code (PERC) of 'BC'.

(b) Renal Disease: Any Medicaid-only Member who was an OHP Client receiving health services in fee-for-service (FFS) on October 31, 2012 that had at least two different claims during the last 36 months with any 585.x Diagnosis Code, including any Member who was in fee-for-service on October 31, 2012 with renal disease, and not just those with End Stage Renal Disease.

(c) Human Immunodeficiency Virus (HIV): Any Member who was an OHP Client receiving health services in FFS on October 31, 2012 that had at least two different claims during the last 36 months with any 042 or 043 or V08 Diagnosis Code.

(d) Medically Fragile Children: Any Member under the age of 19 with a Case Descriptor of 'MFW', 'MFN', or 'MIW' on their current eligibility record.

(e) OMIP: Any Member who was enrolled in the Oregon Medical Insurance Pool (OMIP) on December 31, 2013.

(9) **"SNRG Rate Group"** means the special needs risk category of Members identified in the rates as the SNRG rate group.

(10) **"Target Amount"** means an amount equal to the SNRG base rate plus 50% of the administrative allowance (provider tax is not included in the target calculation).

b. Operation of the CCO Risk Corridor

Contractor shall comply with the requirements for administration of the risk corridor established in this Section. The CCO Risk Corridor utilizes specific percentages above and below a target amount, establishing "bands" of risk, which define how the Contractor and OHA will review the adjusted costs of the SNRG Rate Group over the Risk Corridor period, subject to settlement.

c. Settlement Process

(1) Completion of data submissions. For the data period 2012/2013 and through data period 2014 (26 months), reporting is due not later than June 30, 2015. For the data period 2015 (12 months) is due not later than June 30, 2016. Contractor shall submit the following information to OHA for SNRG Members for dates of service during the Risk Corridor period.

(a) Timely and accurate encounter data for all covered contracted services for SNRG Members.

(b) An invoice in a form specified by OHA. This invoice must show:

(i) The aggregate allowable expenses for all SNRG Members. Aggregate data does not include claims level or Member specific information.

(ii) Reinsurance claims attributable to SNRG Members for the Risk Corridor period notwithstanding whether the claim has been paid, and information about premium costs attributable to the SNRG Rate Group which may reduce the amount of the reinsurance payment offset;

(iii) A line item listing of types and amounts of offsets; and

(iv) An attestation that the information is complete and accurate.

(c) A settlement report in a form specified by OHA with instructions about the methodology for reporting and determining Adjusted Expenses. Adjusted Expenses will be divided by the number of SNRG Member Months, yielding the Adjusted Expenses on a per member per month basis.

(2) OHA will compare the Contractor's reports with the encounter data. OHA may request additional information if needed for clarification.

(3) Adjusted Expenses calculated on a per member per month basis (PMPM) will be compared with the Target Amount.

(4) The outcome of this process will be used to determine whether OHA owes a payment to the Contractor or the Contractor has a charge due to the OHA.

d. Payments and Charges

(1) OHA payments to Contractor: Contractor will receive a payment from OHA in the following amounts under the following circumstances:

(a) When Contractor's Adjusted Expenses (PMPM) for the Risk Corridor period are more than 105 percent but not more than 110 percent of the Target Amount, OHA pays Contractor an amount equal to 50 percent of the Adjusted Expenses (PMPM) in excess of 105 percent of the Target Amount, multiplied by the number of SNRG Member Months; and

(b) When Contractor's Adjusted Expenses (PMPM) for the Risk Corridor period are between 110 percent and more than 120 percent of the Target Amount, OHA pays to the Contractor an amount equal to 80 percent of the Adjusted Expenses (PMPM) in excess of 110 percent of the Target Amount, multiplied by the number of SNRG Member Months; and

(c) When Contractor's Adjusted Expenses (PMPM) for the Risk Corridor period are more than 120 percent of the Target Amount, OHA pays Contractor an amount equal to 100 percent of Adjusted Expenses (PMPM) in excess of 120 percent of the Target Amount, multiplied by the number of SNRG Member Months.

(2) Contractor remittance of Charges: Contractor must remit charges to OHA in the following amounts under the following circumstances:

(a) If the Contractor's Adjusted Expenses (PMPM) for the Risk Corridor period are less than 95 percent but not less than 90 percent of the Target Amount, the

Contractor must remit charges to OHA in an amount equal to 50 percent of the difference between 95 percent of the Target amount and the Adjusted Expenses (PMPM), multiplied by the number of SNRG Member Months; and

(b) When Contractor's Allowable Expenses (PMPM) for the Risk Corridor period are less than 90 percent of the Target amount, the Contractor must remit charges to OHA in an amount equal to 80 percent of the difference between 90 percent of the Target Amount and the Adjusted Expenses (PMPM), multiplied by the number of SNRG Member Months; and

(c) When Contractor's Allowable Expenses (PMPM) for the Risk Corridor period are less than 80 percent of the Target Amount, the Contractor must remit charges to OHA in an amount equal to 100 percent of the difference between 80 percent of the Targeted Amount and the Adjusted Expenses (PMPM), multiplied by the number of SNRG Member Months.

(3) Lump sum or adjusted monthly payments. OHA will, after conferring with the Contractor about the method and timing of the payment or charge, make the payment or require the charge in a lump-sum or by adjusting monthly payments in the following payment year.

7. 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 " ***"Oregon CY16 – Coordinated Care Organization Rate Certification"*** (the "Actuarial Report"). The Actuarial Report is available at http://www.oregon.gov/oha/analytics/Pages/OHPrates.aspx. The Actuarial Report is not part of this Contract, and except where specifically referred to herein, may not be used in the interpretation or construction of this Contract.

8. Administrative Performance Withhold

With implementation of the Administrative Performance (AP) Standard, OHA utilizes an AP Withhold APW methodology in accordance with Exhibit B, Part 8, Section 7.d.

9. Quality Pool

Upon CMS approval, Contractor will be eligible for additional payments under the Quality Pool in accordance with Exhibit B, Part 9.

10. Minimum Medical Loss Ratio:

a. Subject to CMS approval, OHA will implement a Minimum Medical Loss Ratio (MMLR) **Standard** and will utilize the MMLR methodology described in this Section 11. The MMLR process will not alter OHA's authority to administer any other provisions under the Contract.

b. The purpose of this Section 10 is to require Contractor to maintain a Minimum Medical Loss Ratio of at least 80% for the Expansion Population and to require Contractor to rebate any dollar

amount by which its performance falls short of this ratio. The MMLR methodology requires Contractor to submit an annual certified MMLR Report.

c. For purposes of the MMLR methodology and calculations, the following definitions apply:

(1) **Case Rate Revenue** means any payments made on a case rate basis, including maternity and bariatric case rates.

(2) **Change in Contract Reserves** means change during the Reporting Period in **reserves** that are established which, due to the Gross Premium pricing structure, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation Net Premiums at that time. Contract reserves do not include premium deficiency reserves or reserves for expected MMLR Rebates.

(3) **Expansion Population** means Members who are enrolled under this **Contract** in the following Rate Categories: ACA Ages 19-44, ACA Ages 45-54 and ACA Ages 55-64.

(4) **Experience Rating Refunds** means retrospective premium adjustments **arising** from retrospectively rated contracts, plus any incurred state premium refunds.

(5) **Federal and State Taxes and Licensing or Regulatory Fees** means those taxes and licensing or regulatory fees, defined in the Minimum medical Loss Ratio Rebate Calculation Instructions located on the Contract reports Web Site.

(6) **Gross Premiums** means Capitation Payments plus Case Rate Revenue.

(7) **Health Care Quality Improvement Expenses Incurred** means those quality improvement expenses defined in the Minimum Medical Loss Ratio Rebate Calculation Instructions located on the Contract Reports Web Site.

(8) **HRA Payments** means hospital reimbursement adjustment payments.

(9) **Incurred Medical Incentive Pools and Bonuses** means risk sharing and other arrangements with Participating Providers whereby the Contractor agrees to share savings with Participating Providers or to pay bonuses based on achieving defined measures and/or outcomes.

(10) **Minimum Medical Loss Ratio** or **MMLR** means Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.

(11) **MMLR Report** means Contractor's report of financial information required for calculating MMLR, as required by this Section 10.

(12) **MMLR Standard** means an MMLR exceeding 80% for the Expansion Population.

(13) **Net Premiums** means Gross Premiums reduced by:

(a) Reinsurance/Stop Loss Premiums Paid;

(b) HRA Payments; and

(c) Federal and State Taxes and Licensing or Regulatory Fees

(14) **Other Health Care Related Revenues** means supplemental revenues, such as Quality Pool payments **by** OHA.

(15) **Other Incurred Medical Costs** means medical costs not otherwise classified.

(16) **Paid Claims** means amounts paid for claims through March 31 of the year following the Reporting Period that were for services incurred or provided during the Reporting Period.

(17) **Rebate means** the dollar amount which, if added to Contractor's Total Incurred Medical Related Costs, would result in an MMLR equal to the MMLR Standard. If Contractor's MMLR exceeds the MMLR Standard, the Rebate is zero.

(18) **Reinsurance/Stop Loss Premiums** means premiums paid for reinsurance or stop loss insurance but **does** not include reinsuring all or substantially all of Contractor's risk.

(19) **Reporting Period** means:

(a) July 1, 2014 to December 31, 2015 (eighteen (18) months); or

(b) For subsequent years, the calendar year.

(20) **Reserves for Experience Rating Refunds** means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(21) **Sub-Capitated Payments** means a pre-determined payment arrangement made to a Subcontractor in return for Services provided to Members under the Contract

(22) **Total Incurred Medical Costs** means the sum of:

(a) Paid Claims;

(b) Unpaid Claim Reserve;

(c) Incurred Medical Incentive Pools and Bonuses;

(d) Experience Rating Refunds and Reserves for Experience Rating Refunds;

(e) Change in Contract Reserves; and

(f) Other Incurred Medical Costs.

(23) **Total Incurred Medical Related Costs** means the sum of:

(a) Total Incurred Medical Costs; and

(b) Health Care Quality Improvement Expenses Incurred.

(24) **Total Medical Related Revenues** means the sum of Net Premiums and Other Health Care Related Revenues.

(25) **Unpaid Claim Reserve** means reserves and liabilities established to account for claims incurred during the Reporting Period that were unpaid as of March 31 of the year following the Reporting Period.

d. Contractor shall meet or exceed the MMLR Standard for each Reporting Period. In the event Contractor's MMLR falls below the MMLR Standard for a Reporting Period, Contractor shall be obligated to OHA for a Rebate, in accordance with this Section 11.

e. Contractor shall file its MMLR Report electronically utilizing the Minimum Medical Loss Ratio Rebate Calculation Template (Excel Workbook) and following the Minimum Medical Loss Ratio Rebate Calculation Instructions located on the Contract Reports Web Site. All information reported on the MMLR Report must be for revenues and expenses under this Contract or a predecessor CCO contract and must be segregated for the Expansion Population. The MMLR Report must be certified by an officer of Contractor, under penalty of false claims act liability, in the manner required by the MMLR Reporting Instructions.

f. Contractor shall file its MMLR Report for each Reporting Period with OHA's Contract Administration Unit each year by June 30 of the year following the Reporting Period.

g. OHA will review Contractor's filed MMLR Report as follows.

(1) If OHA determines that Contractor's MMLR Report is complete and **accurate** and that Contractor's MMLR meets the MMLR Standard, OHA will issue a final determination that no Rebate will occur for the Reporting Period.

(2) If OHA determines that Contractor's MMLR Report is incomplete or inaccurate, OHA will provide or request proposed revisions to the MMLR Report. Contractor shall supply any information requested by OHA in connection with the MMLR Report within 10 Business Days of the request. The revised MMLR Report will become final for purposes of the MMLR calculations 10 Business Days after the date of the revisions, unless OHA receives from Contractor a written notice of appeal for the applicable Reporting Period not later than 10 Business Days after the date of the revisions. The notice of appeal from the Contractor must include written support for the appeal.

(3) Any appeal shall be conducted as an administrative review. The administrative review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that administrative review is the sole avenue for review of MMLR Reports that it has appealed. The decision on administrative review will result in a final MMLR Report if an appeal was timely filed.

(4) OHA will rely upon the final MMLR Report to determine whether the Contractor is subject to a Rebate for the Reporting Period and the amount of any Rebate.

(5) OHA will conduct this review, verifying the Rebate, if any, and notifying the Contractor no later than September 30 of the year in which the MMLR Report is filed.

h. OHA will confirm with Contractor any Rebate to OHA required due to an MMLR not meeting the MMLR Standard. If a Rebate is due to OHA, the amount will be offset against future CCO Payments.

11. Intent to Amend Rates; Automatic Termination, If Not Amended

The Capitation Rates and the Actuarial Report apply to dates of service earlier than January 1, 2016 (the "Rate Amendment Date"). The parties intend to amend this Contract to supply Capitation Rates and an Actuarial Report for dates starting on the Rate Amendment Date (a "Rate Amendment"). In accordance with CMS determination, OHA shall notify Contractor not less than 120 days before the Rate Amendment Date of its intent to not proceed with a Rate Amendment. Contractor shall notify OHA not less than 120 days before the Rate Amendment Date of its intent to not proceed with a Rate Amendment. If the parties have not entered into a Rate Amendment by the Rate Amendment Date, then this Contract will terminate on the Rate Amendment Date automatically and without any requirement for notice between the parties.

Exhibit C – Consideration - Attachment 1 – CCO Payment Rates

This Attachment 1 includes all CCO rate types. The following table is marked by a "yes" to reflect which rate types apply to this Contract.

For the period of January 1, 2016 through December 31, 2016 the following rates apply:

Yes	No	Rate Type
X		CCO A - All Services
X		CCO B – Physical Health and Mental Health Services
X		CCO E – Mental Health Services Only
X		CCO G – Mental Health and Dental Health Services Only

(Specific Plan Rates are set forth at the end of the contract as referenced in Attachment 1 to Exhibit C)

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, or both, 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 brought and 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 by 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 integrated and coordinated care and services, OAR Chapter 410, Division 141; (iii) all other OHA Rules in OAR Chapter 410; (iv) rules in OAR Chapter 309 pertaining to the provisions of mental health services; (v) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (vi) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (vii) 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, ORS 279B.225, 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 or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, 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; Payments

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. **Payment Method.** Payments under this Contract will be made by Electronic Funds Transfer (EFT), unless otherwise mutually agreed, and shall be processed in accordance with the provisions of OAR 407-120-0100 through 407-120-0380 or OAR 410-120-1260 through OAR 410-120-1460, as applicable, and any other OHA Oregon Administrative Rules that are program-specific to the billings and payments. Upon request, Contractor shall provide its taxpayer identification number (TIN) and other necessary banking information to receive EFT payment. Contractor shall maintain at its own expense a single financial institution or authorized payment agent capable of receiving and processing EFT using the Automated Clearing House (ACH) transfer method. The most current designation and EFT information will be used for all payments under this Contract. Contractor shall provide this designation and information on a form provided by OHA. In the event that EFT information changes or the Contractor elects to designate a different financial institution for the receipt of any payment made using EFT procedures, the Contractor shall provide the changed information or designation to OHA on an OHA-approved form. OHA is not required to make any payment under this Contract until receipt of the correct EFT designation and payment information from the Contractor.

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. Indemnity

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, IN A FORM AND MANNER DETERMINED APPROPRIATE BY 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 as specified in 42 CFR 438.610, 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, changes in Covered Services or CCO Payments under ORS 414.735, or other circumstances described in Exhibit D, Paragraph 20.b.;

(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; and

(c) That Contractor does not accept the amendment or 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 33 through 36 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 D 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 or case rate or supplemental payments as identified in Exhibit C less previous amounts paid and any claim(s) that OHA has against Contractor. In no event shall OHA be liable to Contractor for any expenses related to termination of this Contract or for anticipated profits. 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 overpayments 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 written notice if OHA fails to receive funding, appropriations, limitations, allotments or other expenditure authority at levels 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.

(d) Contractor has failed to carry out the substantive terms of its Contract or meet the applicable requirements of 1932, 1903(m) or 1905(t) of the Social Security Act.

(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 with written notice to OHA not later than 120 days prior to the date of any Renewal Contract, for termination effective at the renewal date.

(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) Automatic Termination. This Contract will terminate automatically under the condition described in Exhibit C, Section 11.

(8) 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 180 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 during the term of this Contract; 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.

(9) 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 Covered 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.**

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) Covered Services authorized or required to be provided under this Contract.

12. Insurance

Contractor shall maintain insurance as set forth in Exhibit F, attached hereto.

13. Access to Records and Facilities

Contractor shall maintain, and require its Subcontractors to maintain, all financial records relating 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 shipments and payments and writings of Contractor, whether in paper, electronic or other form, that are pertinent to this Contract, in such a manner as to clearly document Contractor's performance. All Clinical Records, 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, DHHS, 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 and to evaluate the quality, appropriateness and timeliness of services. Contractor shall retain and keep accessible all Records for the longer of:

a. For non-clinical records, six years following final payment and termination of this Contract, whichever is later;

b. For Clinical Records, seven years following the Date of Service;

c. The retention period specified in this Contract for certain kinds of records;

d. The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or

e. 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 section 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 943-014-0300 through 943-014-0320, 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 943-014-0305, 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 cause of delay or default and shall, upon the cessation of the cause, diligently pursue performance of its obligations under this Contract. OHA may terminate this Contract upon written notice to Contractor after reasonably determining that the delay or default will likely prevent successful performance of 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 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, Sections 13 and 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 22 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 13.

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. The parties agree that Contractor's performance under this Contract is solely for the benefit of OHA to accomplish its statutory mission. 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 any 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

a. OHA may amend this Contract to the extent provided herein, or in RFA 3402, and to the extent permitted by applicable statutes and administrative rules. No amendment, modification or change of terms of this Contract shall bind either party unless in writing and signed by both parties and when required approved by the Department of Justice. Such amendment, modification or change, if made, shall be effective only in the specific instance and for the specific purpose given.

b. OHA may provide Contractor with an amendment to this Contract under any of the following circumstances:

(1) 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.

(2) 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.

(3) If this Contract is amended to reduce or expand the Service Area, reduce or expand the Enrollment limit, or both, and a CCO Payment Rate change is made under Exhibit B, Part 4, Section 11.

(4) To the extent such changes are required to obtain CMS approval of this Contract or the CCO Payment Rates.

OHA will send to Contractor the necessary Contract amendments no later than 60 days before the proposed effective date of the amendment. Failure of Contractor to enter into an amendment described in this paragraph, as necessary for the amendment to go into effect on its proposed effective date, is a default of Contractor under Exhibit D, Paragraph 10.a(6).

c. Per capita rates are actuarially certified annually. Rates will be amended annually along with required language changes, as allowed for in ORS 414.625 (1) and Exhibit C, Section 11.

d. 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. Waiver

No waiver or other consent under this Contract shall bind either party unless it is in writing and signed by the party to be bound. Such 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 provision.

22. 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.

23. Survival

Sections 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 22 and 23 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.

24. Notices

a. Except as otherwise expressly provided in this Contract, any notices or other communications between the parties hereto or notices to be given hereunder must be given in writing by personal delivery, facsimile, email, express mail, or postal mail. The expenses of delivery must be prepaid. Any such communication or notice is deemed received:

(1) If given by personal delivery, when actually delivered to the addressee.

(2) If delivered by facsimile, on the day the transmitting machine generates a receipt of the successful transmission, if transmission was during normal business hours of the recipient, or on the next Business Day if transmission was outside normal business hours of the recipient. Notwithstanding the foregoing, to be effective against the other party, any notice transmitted by facsimile must be confirmed by telephone notice to the other party at the number listed below.

(3) If delivered by email, when the addressee personally acknowledges receipt. An automatically generated message is not an acknowledgment of receipt.

(4) If delivered by express mail, on the day of delivery if a Business Day or the otherwise the next Business Day.

(5) If delivered by regular mail, five Business Days after the date of mailing.

b. Notices or other communications to Contractor or OHA must be directed to the address or number set forth below, or to such other addresses or numbers as either party may indicate pursuant to this section. Except as otherwise expressly provided in this Contract, the parties' contact information is:

OHA: Office of Contracts & Procurement
DHS
250 Winter Street NE, Room 306
Salem, Oregon 97301
Telephone: 503-945-5818
Facsimile: 503-378-4324

Contractor: See Contract Document, Section IV.B

25. 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. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. Mandatory Reporting

a. 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.

b. Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in any of the following laws:

(1) OAR 943-045-0250 through 943-045-0370 (abuse investigations by the Office of Investigations and Training);

(2) ORS 430.735 through 430.765 (persons with mental illness or developmental disabilities);

(3) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse); and

(4) ORS 441.650 to 441.680 (residents of long term care facilities)

32. 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 Contractor 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 Sections 32 through 35 of this Exhibit D.

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 33 through 36, of this Contract, and pursue other remedies available under this Contract.

33. Conditions that May Result in Sanctions

OHA may impose Sanctions, as specified in Sections 33 through 35 of this Exhibit D, if it determines that Contractor has acted or failed to act as described in this Section 33 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 protected class (such as race, color national origin, religion, sex, sexual orientation, marital status, age, or disability), their health status or their 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 this Contract, or any practice that would reasonably be expected to discourage Enrollment by individuals whose protected class , 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, Parts 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 9; or

u. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

34. 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 Subsection a., above;

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 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, in accordance with 42 CFR 702(b), reasonably designed to remedy or compel future compliance with this Contract.

35. 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 calendar 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 Section 33, Subsection h, of this exhibit, 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 CCO Payment(s) or as otherwise provided under this Contract, until the Recovery Amount payment is satisfied.

b. The Administrative Review process described in Section 33, Subsection h, of this Exhibit D and this Section 35, 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 33 through 36 of this Contract.

c. If the State imposes a civil monetary penalty on the Contractor for charging premiums or charges in excess of the amounts permitted under Medicaid(i.e., excessive copays, etc.), the State will deduct the amount of the overcharge from the penalty and return the excess to the Member.

36. 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 Subsection a through f, or q, of Section 33 of this Exhibit D, 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 require 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 require 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 laws requiring reporting of Member 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 U.S.C. 14402.

2. Equal Employment Opportunity

If this Contract, including amendments, is for more than $10,000, then Contractor shall comply and require 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 require 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, United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and require 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 require 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

By signing this Contract, 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.

e. No part of any federal funds paid to Contractor under this Contract shall be used other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

f. No part of any federal funds paid to Contractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the United States Congress

or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

g. The prohibitions in subsections (e) and (f) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction an any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

h. No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

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 its implementing federal regulations (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 Members 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 Chapter 407 Division 014, 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/cf1/FORMS/, Form number ME2090 Notice of Privacy Practices, 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 require 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 U.S.C. 6901 et seq.). Section 6002 of that Act (codified at 42 U.S.C. 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

a. Contractor shall comply, and require all subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

b. If Contractor expends $500,000 or more in Federal funds (from all sources) in its fiscal year beginning prior to December 26, 2014, Contractor shall have a single organization-wide audit conducted in accordance with the Single Audit Act. If Contractor expends $750,000 or more in federal funds (from all sources) in a fiscal year beginning on or after December 26, 2014, Contractor shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be submitted to OHA within 30 days of completion. If Contractor expends less than $500,000 in Federal funds in a fiscal year beginning prior to December 26, 2014, or less than $750,000 in a fiscal year beginning on or after that date, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, Part 8, Section 2.

9. Debarment and Suspension

Contractor shall, in accordance with 42 CFR 438.808(b), 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. Contractor shall ensure that no amounts are paid to a Provider that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

a. The Provider is controlled by a sanctioned individual

b. The Provider has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act

c. The Provider employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

(i) Any individual or entity excluded from participation in Federal health care programs.

(ii) Any entity that would provide those services through an excluded individual or entity.

The Contract prohibits the Contractor from knowingly having a person with ownership of more than 5% of the Contractor's equity if such person is (or is affiliated with a person or entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.

If OHA learns that Contractor has a prohibited relationship with a person or entity that is debarred, suspended, or excluded from participation in federal healthcare programs, OHA:
a. Must notify DHHS of Contractor's noncompliance;
b. May continue an existing agreement with the Contractor unless DHHS directs otherwise; and
c. May not renew or extend the existing contract with the Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for renewing or extending the Contract, consistent with 42 CFR 438.610.

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 Members. 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 require all Subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et seq.).

12. Additional Medicaid and CHIP

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. 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.

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.

Contractor is prohibited from conditioning the provision of care or otherwise discriminating against a Member based on whether or not the individual has executed an advance directive per 42 CFR 438.6(i)(1)); 42 CFR 422.128; or 42 CFR 489.102(a)(3).

16. 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.

17. 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.

18. 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 same meaning as "personal and substantial" as set forth in 5 CFR 2635.402(b)(4).

19. Non-Discrimination

Contractor shall comply, and require its Subcontractors to 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.

20. 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 42 CFR 484.20, and such subsequent regulations as CMS may issue in relation to the OASIS program.

21. 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.

22. 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 92 (uniform administrative requirements for grants to state, local and tribal governments);

c. Part 80 (nondiscrimination under Title VI of the Civil Rights Act);

d. Part 84 (nondiscrimination on the basis of handicap);

e. Part 91 (nondiscrimination on the basis of age);

f. Part 95 (Medicaid and CHIP federal grant administration requirements); and

g. 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 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). If Contractor is a subject employer, as defined in ORS 656.023, Contractor shall obtain employers' liability insurance coverage. Contractor shall require and ensure that each of its Subcontractors complies with these requirements.

2. **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:

   Per occurrence limit for any single Claimant of not less than $2,000,000, and
   Per occurrence limit for multiple Claimants of not less than $4,000,000.

3. **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

   A combined single limit per occurrence of not less than $2,000,000, and
   An aggregate limit for all claims of not less than $4,000,000.

   AND

   Property Damage:

   A combined single limit per occurrence of not less than $200,000, and
   An aggregate limit for all claims of not less than $600,000.

4. **Automobile Liability:** Insurance covering 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

   A combined single limit per occurrence of not less than $2,000,000, and
   An aggregate limit for all claims of not less than $4,000,000.

AND

Property Damage:

A combined single limit per occurrence of not less than $200,000, and
An aggregate limit for all claims of not less than $600,000.

From July 1, 2016 and every year thereafter, the coverage limitations set forth herein shall be adjusted to comply with the limits determined by the State Court Administrator pursuant to ORS 30.271(4).

5. **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.

6. **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.

7. **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.

8. **"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.

9. **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. Stop-loss insurance and reinsurance coverage against catastrophic and unexpected expenses may not be self-insured.

Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy

1. Delivery System Network (DSN) Reports

Contractor shall demonstrate its DSN Provider Capacity by submitting a DSN Provider Narrative Report and a DSN Provider Capacity Report to OHA as specified in this Section 1 no later than July 1st of every year. Subsequently, Contractor shall update these reports any time there has been a Material Change in Contractor's operations that would affect adequate capacity and services, and upon OHA request.

a. DSN Provider Narrative Report

(1) Pursuant to 42 CFR 438.206 "Availability of Services" and 42 CFR 438.207 "Assurances of Adequate Capacity and Services," Contractor shall ensure to OHA, with supporting documentation, that all Covered Services are available and accessible to Members and that the Contractor demonstrates adequate Provider capacity. Pursuant to 42 CFR 438.206(c)(1)(vi), Contractor shall take corrective action if it or its providers fail to comply with the timely access requirements.

(2) Contractor shall provide the following information of how it requires and monitors adequate Provider capacity. If any of the activities are subcontracted, Contractor shall describe how it provides oversight and monitoring of the activities as well. Contractor may elect to contract for or to delegate responsibility for the reporting and monitoring of adequate Provider capacity; however, Contractor shall be responsible for the following activities, including oversight of the following processes, regardless of whether the activities are provided directly, contracted or delegated.

(a)

(i) How does Contractor maintain a DSN of appropriate Providers to sufficiently provide adequate access to all Covered Services including Special Health Care Needs?

(ii) How does Contractor monitor the DSN of appropriate Providers to sufficiently provide adequate access to all services covered under this Contract including Special Health Care Needs?

(b) If the DSN is unable to provide necessary Covered Services, to a particular Member, how does Contractor provide adequate and timely services out of its DSN for a Member, for as long as the Contractor is unable to provide them within its DSN?

(c)

(i) How does Contractor 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?

(ii) How does Contractor monitor compliance by Providers of timely access to care and services?

(iii) How does Contractor monitor availability of services when Medically Appropriate routine, urgent and emergent services?

(d) What Corrective Actions has Contractor 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 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.

b. DSN Provider Capacity Report

Contractor shall describe its DSN capacity by submitting a DSN Provider Capacity Report on July 1st of every year, with its DSN Provider Narrative as described above, for the following categories of services or types of service providers. Contractor's DSN service providers, whether employed by or under subcontract with Contractor or paid fee-for-service, must have agreed with Contractor to provide the described services or items to Medicaid and Fully Dual Eligible Members. Contractor shall base its DSN upon its community health assessment (if available), community health improvement plan (if available), and Transformation Plan for delivery of integrated and coordinated health, Dental Services, mental health, and Substance Use Disorders treatment services and supports.

(1) Contractor shall include in its DSN Provider Capacity Report the data elements in Subsection (2)(b) below about each Provider or facility Subsection (2)(a) below, using Excel format; however, certain categories of providers may be described in narrative form as described in Subsection (3) below.

(a) Providers should be grouped by category. For example, all Substance Use Disorders treatment Providers should be listed together; all Ambulance and Emergency Medical Transportation Providers should be listed together.

(b) For patient centered primary care homes, a listing of the Providers who participate in that PCPCH should be listed together; it is not necessary to duplicate those same Providers in the other categories. Information should include the certification Tier and number of Members covered by the Provider.

(c) For Mental Health Crisis Services, Contractor shall list separately the number of Crisis Hot Lines, Crisis Walk in Centers, Mobile Crisis Teams, Crisis Respite Centers and Short-term Crisis Stabilization Units.

(2) Required Data Elements:

(a) Practitioners and Facilities:

(i) Name of Practitioner or Facility
(ii) Type of Practitioner or Facility

(iii) Address
(iv) Telephone number
(v) NPI number
(vi) Non-English language spoken

(b) Category of Service

(i) Acute inpatient hospital psychiatric care
(ii) Ambulance and Emergency Medical Transportation
(iii) Certified or Qualified Health Care Interpreters
(iv) Certified Traditional Health Workers
(v) Community prevention services
(vi) Dental Services Providers
(vii) Federally qualified health centers
(viii) Health education, health promotion, health literacy
(ix) Home health
(x) Hospice
(xi) Hospital
(xii) Imaging
(xiii) Indian Health Service and tribal health services
(xiv) Mental health Providers
(xv) Mental Health Crisis Services
(xvi) Non-Emergent Medical Transportation
(xvii) Oral health Providers
(xviii) Palliative care
(xix) Patient Centered Primary Care Homes
(xx) Pharmacies and durable medical Providers
(xxi) Post-hospital skilled nursing facility
(xxii) Primary Care Providers
(xxiii) Rural health centers
(xxiv) School-based health centers
(xxv) Specialty practitioners
(xxvi) Substance Use Disorders Providers
(xxvii) Traditional Health Workers
(xxviii) Urgent care center
(xxix) Others not listed but included in the Contractor's integrated and coordinated service delivery network.

(3) Narrative Information for other Provider categories: The categories of Certified Traditional Health Workers and Traditional Health Workers may not be suitable for the foregoing format. Contractor may describe in narrative form how its DSN makes provision of these services, their training and supervision, and their integration into the Contractor's integrated and coordinated care delivery system.

c. Cooperative Agreements with Publicly Funded Programs Report:

To implement and formalize coordination and ensure relationships exist between Contractor and publicly funded health care and service programs, Contractor shall complete the following table and submit it to the OHA Contract Administration Unit by July 1st of every year, and provide additional information upon OHA request.

Name of publicly funded program	Type of public program [*(e.g., county mental health dept.)*]	County in which program provides services	Does Contractor have a Memorandum of Understanding? [*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 the Community Advisory Council, on Quality Assurance Committee, specify if subcontract, etc.)?
	Local Mental Health Authority			
	Community Mental Health Programs			
	Type B AAA			
	State APD district offices			
	Local public health authority			

d. Cooperative Agreements with Community Social and Support Service and Long Term Care Report:

To implement and formalize coordination and ensure relationships exist between Contractor and the following entities, Contractor shall provide the following information in a brief narrative report or table and submit to the OHA Contract Administration Unit by July 1st of every year, and provide additional information upon OHA request.

(1) Referral and cooperative arrangements with culturally diverse social and support services organizations, required to be established by Exhibit B, Part 4, Subsection (5)(c).

(2) Cooperative arrangements and agreements to provide for medications with residential, nursing facilities, foster care and group homes, required by Exhibit B, Part 4, Subsection (5)(e).

(3) Cooperative arrangements and agreements with DHS Child Welfare offices to assure timely assessments for Member children placed under Child Welfare custody, as required by Exhibit B, Part 2, Subsection(4)(m)(3)(g).

2. Hospital Network Adequacy

a. This Hospital Adequacy Report is an annual report of admissions and paid amounts 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. The reporting period for this report shall be from January 1, 2015 through December 31, 2015. Contractor shall submit to the OHA Contract Administration Unit (CAU) by March 31 following the end of the reporting period the Hospital Adequacy Report available on the Contract Reports Web Site. 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.

3. 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.

4. 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.

5. 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.

h. 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.

i. 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 or provides documentation to OHA that it 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 H.
- 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 located on the Contract Reports Web Site.

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.

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 5, Subsection a, and conduct survey as required in Section 6 of this Exhibit.

a. PIP Stop Loss Protection

Stop-loss Protection must be in place to protect physicians and 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.

5. 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 H.

6. 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 and OHA with a summary of survey results.

7. Monitoring:

a. Contractor shall file the CMS PIP Disclosure Form located on the Contract Reports Web Site.

b. The CMS PIP Disclosure Form, -as posted on the Contract Reports Web Site, is subject to review and revision by OHA.

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 Member 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 an Appeal.

(3) A Member may file a Grievance with OHA or the Contractor. OHA shall promptly send the Grievance to the Contractor.

b. Timing

Within 45 Business Days from the date on the Notice of Action (NOA):

(1) The Member or Provider may file an Appeal; and

(2) The Member 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 shall meet the language and format requirements in Exhibit B, Part 3, Section 4 and be consistent with the requirements of OAR 410-141-3280, 410-141-3300 and 42 CFR 438.10. Written notice must be translated for Members who speak prevalent non-English languages, as defined in 42 CFR 438.10 (c), and notices must include language clarifying that oral interpretation is available for all languages and how to access it, 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;

(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); or

(g) Contractor denies Member's disenrollment request and finds there is not good cause for such request.

(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 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 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 days following receipt of the request for service, except that:

(i) The Contractor may have an extension of up to 14 additional 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 or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care 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 Professionals who have the appropriate physical health, behavioral health (which includes mental health and Substance Use Disorders), and oral health 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 Medically Appropriate services,

(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 Member Representative the 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 Member 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 five Business 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 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 OHP Client Services Unit (CSU) toll free at 800-273-0557 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 CSU or OHA's Ombudsman, including providing all requested records.

(4) Standard Resolution for Appeals

All Appeals must be received no later than 45 days from the date on the NOA. Contractor shall resolve each Appeal as expeditiously as the Member's health condition requires and no later than 14 days from the day the Contractor receives the Appeal. The Contractor may extend this timeframe by up to 14 days if:

(a) The Member requests the extension; or

(b) 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.

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 in 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 days after receipt of the request for service.

(b) Resolve each expedited Appeal request, as expeditiously as the Member's health condition requires, 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 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 4.a., above; and

(ii) Make reasonable efforts to give the Member prompt oral notice of the denial, and follow-up within two Business 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 Business 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. The written notice of resolution of an Appeal shall include the following:

(a) The results of the resolution process and the date it was completed;

(b) For Appeals not resolved wholly in favor of the Member:

(i) 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);

(ii) The right to continue to receive benefits pending a Contested Care Hearing;

(iii) Information stating how to request the continuation of benefits, and

(iv) Information explaining how if the 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:

a. As used in this section, "timely" filing means filing on or before the later of the following:

(1) Within 10 days after the Contractor mails the Notice of Action; or

(2) The intended effective date of the Contractor's proposed Action.

b. 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.

c. 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.

d. 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 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. Expedited resolution of an Appeal made directly to OHA, without first accessing the Contractor Appeal process, shall be conducted as expeditiously as the Member's health condition requires, and must occur within three Business Days from OHA receipt of a

hearing request for a denial of a service that meets the criteria for an expedited Appeal process. The final order is the final decision of OHA.

8. Documentation and Quality Improvement

a. Contractor shall document all Grievances and Appeals using the Grievance Log and Summary Workbook available on the Contract Reports Web Site in accordance with the instructions included on each report and shall submit it to OHA Contract Administration Unit 45 days following the end of each calendar quarter. Contractor shall monitor the Grievance Reports internally 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 Forms. 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 Contract Administration Unit, upon request by OHA, samples of NOAs or other information about the Contractor's NOA processes. The NOA recommended sample size is twenty per quarter per Contractor.

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 - Review Tool for CCO Informational Materials and Member Education

Contractor is responsible for preparing a Member handbook to provide informational materials and Member education. Mailing of Member handbooks shall occur within 14 days of receiving OHA's initial 834 listing of Member's Enrollment (or re-enrollment after not being enrolled for 90 days or more) with the Contractor; however Contractor may deliver the Member handbook electronically if the Member has requested or approved electronic transmittal consistent with Exhibit B, Part 3, Section 2.s. and t. of this Contract. Contractor shall review the Member handbook annually and revise it as needed to keep it accurate. Contractor shall notify all existing Members of each revision and its location on Contractor's web site, and offer to send the Member a printed copy on request. Contractor's Member handbook shall incorporate all of the elements included in the Review Tool. The Review Tool is included in this Contract as an appendix to Exhibit J. The Review Tool can also be found on the CCO forms page.

For each item listed in the Review Tool, the column labeled "Text Provided by OHA or Contractor" describes whether OHA or the Contractor is responsible for developing the text. The DMAP Materials Coordinator will provide OHA text which may be modified and completed as needed for accuracy, and the CCO will develop the text for items identified on the tool as "Text Provided by Contractor". Informational materials provided by OHA to the CCO will be available the prevalent languages in the Service Areas, in accordance with the Contract and Contractor shall compile a Member handbook in each prevalent language for the Members who speak those languages.

The Contractor shall review the Member handbook for accuracy at least yearly, updating with new or corrected information as needed to reflect the Contractor's internal changes and any regulatory changes. Contractor shall submit each version of the CCO handbook to the DMAP Materials Coordinator for approval initially and upon revision or upon OHA request. Compliance with the Review Tool does not replace the Contractor's obligation to satisfy all the requirements of OAR 410-141-3300 and 42 CFR 438.10. The readability standard used in this review will be the Flesch-Kincaid standard used in Word.

Exhibit J – Appendix - Review Tool

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	No	OHA Comments	CCO Response to OHA Comments
1	Both	*Throughout*	6th Grade language, sentences 20 words or less in length, minimum 12 point font				
2	OHA		Tag line translation in all required languages (should be located in the front portion of the handbook)				
3	OHA		Statement of availability of alternate formats, including web site location, and written material translations				
	OHA		Offer to send a Member handbook any time on request				
4	Contractor		Description of the CCO including names of member				

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	For OHA Use Only Item Approved No	OHA Comments	CCO Response to OHA Comments
			organizations, services offered and areas served				
5	OHA		Explanation of OHP, Coordinated Care and PCPCH				
6	Contractor		How CCO will coordinate care, including the role of Patient-centered Primary Care Homes (PCPCH)				
7	Contractor		The roles of Certified Traditional Health Workers and Traditional Health Workers and how to access them				
8	Contractor		Contractor's Customer Service telephone numbers, including toll free, TTY/TDD or Oregon Relay 711, and Fax				
9	Contractor		Contractor mailing address, web address, office location and hours of operation				
10	Contractor		I information on CCO's ID card, Oregon Health ID, and OHP Coverage letter				
11	Contractor		How Members choose and make an appointment with a Primary Care Provider				
12	OHA		How to access Certified or Qualified Health Care Interpreter services				
13	Contractor		Any restrictions on the Member's freedom of choice among network providers				
14	OHA		Information on culturally sensitive Contractor or provider-based screenings, health and Behavioral Health care, health education programs, including self-care, prevention, and disease self-management				
15	Contractor		Explanation of Covered and Non-Covered Services and how to access those services and the amount, duration and scope of Covered Services in sufficient detail to ensure that Members understand the benefits to which they are entitled. The extent to which, and how the Member may obtain benefits, including Family Planning Services, from out-of-network providers. Explanation of how and where to access any OHP Benefits that are not covered under this Contract.				
16	OHA		Disenrollment Process: When and how Members can voluntarily and involuntarily disenroll from their CCO and change plans				

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	For OHA Use Only Item Approved No	OHA Comments	CCO Response to OHA Comments
17	OHA		How to access Transportation Services as a part of OHP Benefit				
18	OHA		Member rights and responsibilities, as specified in 42 CFR Section 438.100				
19	Contractor		Transitional procedures for new Members to obtain services in the first month of Enrollment with Contractor if they are unable to see a new provider and get new orders during that period				
20	OHA		How to obtain mental health prescription medication				
21	OHA		Urgent/Emergent Care and how after-hours and emergency coverage are provided , including: a. What constitutes an emergency and use of 911; b. Specify layperson language re: emergencies; c. The fact that Prior Authorization is not required for Emergency Services; d. How to access urgent care services and advice; e. Crisis Services; f. Urgent and Emergent care away from home; g. Post-stabilization services, with reference to the definitions in 42 CFR Section 438.114 (a); h. The fact that, subject to the provisions of this line item 21, the Member has the right to use any Hospital or other setting for emergency care; i. The locations of any emergency settings and other locations at which providers and Hospitals furnish Emergency Services and post-stabilization care services covered under this Contract and 42 CFR 422.113(c)(2)(iii)as related to Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or under the circumstances to improve or resolve the Member's condition				
22	OHA		Information on Member's possible responsibility for charges, including Medicare deductibles and coinsurance if they go				

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	For OHA Use Only Item Approved No	OHA Comments	CCO Response to OHA Comments
			outside of the plan for non-emergent care, and charges for services not covered including information about the need and requirements for a written agreement to pay, or waiver. Information on when a Provider is prohibited from billing a Member for services, and what Members should do when billed by a Provider, including information on who to call about Provider billing.				
23	Contractor		Use of the referral system, including what services must be preauthorized and how to obtain a referral				
24	Contractor		How to obtain copies of Member records, including whether Contractor charges for copying				
25	OHA		Explain Confidentiality policies, including HIPAA Notice of Privacy Practices				
26	OHA		Advance Directives: a. As set forth in 438.6 (i) (2) – all contracts must require the provision to adult Members of written information about Advance Directive policies, including a description of Member rights under applicable State law; b. Information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. c. Contractor's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience				
27	OHA		Member's right to execute a Declaration of Mental Health Treatment in accordance with ORS 127.703 and provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf				
28	Contractor		Provision of educational and pharmacological help for substance abuse and tobacco cessation, which may include quit line number				

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	For OHA Use Only Item Approved No	OHA Comments	CCO Response to OHA Comments
29	OHA		Grievance System Information: Grievance, Appeal and Fair Hearing procedures and timeframes, as provided in 42 CFR Section 438.400 – 438.424 Explain the following: a. The right to file Grievances, Appeals and Contested Case Hearings; b. The toll-free numbers that the Member can use to file a Grievance or Appeal by phone; c. The requirements and timeframes in the filing process for Grievances and Appeals d. The availability of assistance in the filing process; e. The method of obtaining a Contested Case Hearing; f. The rules that govern representation at the Contested Case Hearing. g. The right to have an Attorney or representative present at the Contested Case 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. h. The fact that when requested by the Member; 1. Benefits will continue if the Member files an Appeal or a request for Contested Case Hearing within the timeframes specified for filing; and 2. The Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member. i. Appeal rights available to Providers to challenge the failure of the organization to cover a service				
30	a. Contractor b. OHA		Information available upon request including the following: a. Information on the structure and operation of the CCO b. Physician incentive plans as set forth in 42 CFR 438.6				

Item Number	Text provided by OHA or Contractor	Page Number and Contractor Comments	Requirement	For OHA Use Only Item Approved Yes	No	OHA Comments	CCO Response to OHA Comments
31	Contractor		Opportunities for Member participation in Plan governance including the Community Advisory Committee				
32	Contractor		Handbook date (month and year) located on the front cover				
33	Contractor		List of contracted providers, specialists and Hospitals, in the Member's service area with each subcontractor's name, address, phone, non-English languages spoken, and, if applicable, web site and must include identification of Providers that are not accepting new patients. Contractor's web address for updated Provider list				
34	Contractor		Co-Payment requirements and a statement of plan's intention to ask Providers to collect Co-Payments				
35	OHA		Enrollment requirements as they relate to American Indian and Alaska native Members, and tribal members' right to use IHS and tribal health care services (42 USC 1932)				
36	Contractor		Intensive Care Coordination services and how to access them				
37	OHA – basic benefits Contractor – services and programs		Mental health services and programs available, including AMHI and ISA services				

Exhibit K – Transformation Plan

Contractor has prepared, and OHA has approved, a "Transformation Plan" that is a specific plan (plans, timeline, benchmarks, milestones, and deliverables) demonstrating how and when Contractor will achieve Health System Transformation, aligned with the quality and incentive specifications established in Exhibit B, Part 9. Contractor has prepared, and OHA, DOJ, and CMS have approved, "Areas of Transformation" that are based in substance on the Transformation Plan and in form on the Transformation Deliverables and Benchmarks described below. Contractor's Areas of Transformation are in Attachment 1, which is attached to this Exhibit K and hereby incorporated into this Contract with this reference. Contractor's obligations under the Transformation Amendment are obligations under this Contract. The purpose of this Exhibit K is to set forth the procedure Contractor shall follow to maintain the Transformation Plan and Transformation Amendment required by this Contract.

1. Transformation Plan

Contractor shall maintain a Transformation Plan in effect throughout the term of this Contract. Contractor's Transformation Plan must include, at minimum, the following eight areas of transformation (the "Transformation Areas"):

(a) Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when Dental Services are included. This plan must specifically address the needs of individuals with severe and persistent mental illness.

(b) Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

(c) Implementing consistent Alternative Payment Methodologies that align payment with health outcomes.

(d) Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.

(e) Developing a plan for encouraging Electronic Health Records; health information exchange; and meaningful use.

(f) Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguisitic needs.

(g) Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

(h) 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.

2. Revised Transformation Plan and Areas of Transformation.

At OHA's request, or as required by an amendment to the Contract, Contractor shall make changes to its Transformation Plan and Areas of Transformation by furnishing OHA with a revised draft of the Plan and Areas of Transformation with the requested changes on the date set by OHA. Contractor and OHA will exchange drafts of the Transformation Plan and Areas of Transformation so that OHA approves them on the date set by OHA. Changes to the Areas of Transformation are amendments to this Contract and may be subject to approval by DOJ and CMS.

3. Monitoring and Compliance Review

Contractor agrees to progress toward achieving the objectives and timelines identified in its Transformation Plan and Areas of Transformation and to cooperate with OHA in providing evidence of progress consistent with the Plan and Areas of Transformation. OHA may monitor Contractor's compliance with the requirements in its Transformation Plan and Areas of Transformation 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 and Areas of Transformation. If OHA cannot confirm Contractor's progress toward compliance with its Transformation Plan and Areas of Transformation, OHA will give the Contractor opportunity to demonstrate evidence of progress and compliance with its Plan and Areas of Transformation before seeking to impose Sanctions under Exhibit D, Sections 33 through 36, of this Contract, and to pursue other remedies available under this Contract.

4. Periodic Update of Transformation Plan

Contractor shall periodically update its Transformation Plan and Areas of Transformation to continue implementation of specific plans (timelines, benchmarks, milestones, and deliverables) demonstrating how Contractor continues to work towards the goal to achieve Health System Transformation, aligned with the quality and incentive specifications established in Exhibit B, Part 9. An updated Transformation Plan and Transformation Amendment will be developed for the 2017-2019 cycle and every two years thereafter, using a schedule and accountabilities provided by OHA to Contractor. as follows:

	Deliverable	**Deliverable Date**
(1)	Draft Plan. Contractor furnishes OHA with a draft of an updated Transformation Plan.	March 16, 2017,
(2)	OHA Comments. OHA furnishes Contractor with written comments on	May 15, 2017,

its draft updated Transformation Plan.

(3) Final Draft. Contractor submits final draft language of its updated Transformation Plan for approval by OHA. June 10, 2017

(4) OHA Acceptance. OHA furnishes Contractor with written approval of its draft updated Transformation Plan. July 1, 2017

The updated Transformation Plans and Transformation Amendments are intended to continue the progress of transformation and integration.

5. Transformation Plan Deliverables

Contractor shall provide the following deliverables on the schedule described below (or any amended schedule set by amendment to its Transformation Plan and Areas of Transformation). Contractor shall combine the reports for all Areas of Transformation and Benchmarks into a single report.

Deliverable	Cycle	Deliverable Date
(1) Initial progress report	2015-2017	January 31, 2016
(2) Milestone report	2015-2017	August 31, 2016
(3) Second progress report	2015-2017	January 31, 2017
(4) Benchmark report	2015-2017	August 31, 2017
(5) Initial progress report	2017-2019	January 31, 2018
(6) Milestone report	2017-2019	August 31, 2018
(7) Second progress report	2017-2019	January 31, 2019
(8) Benchmark report	2017-2019	August 31, 2019

Progress, Milestone and Benchmark reports must address each transformation area, including actions taken or being taken to achieve the Milestone and Benchmark, outcome of these activities, and process improvements. Contractor shall also describe how its Community Advisory Council (CAC) was involved in the process and informed of the outcomes in each transformation area.

Progress and Milestone reports must also identify any areas where the Contractor has encountered barriers to achieving a Milestone or Benchmark, and describe its efforts to work with OHA through the Innovator Agent and Learning Collaborative to develop alternative strategies to reach the Benchmark.

6. Benchmarks for Transformation Plan Amendments

Contractor's Areas of Transformation must at all times address the eight Transformation Areas. Within each of the eight Transformation Areas, each Area of Transformation establishes one or more Benchmarks. Progress will be measured from the Baseline. The Areas of Transformation must describe how Contractor will measure progress toward achieving each Benchmark, including one or more Milestones.
A Benchmark and at least one Milestone are required for each Transformation Area. Contractor will report on progress, Milestones and Benchmarks using the schedule described in Section 5.

7. Definitions for Exhibit K

For purposes of this Exhibit K, these terms have the following meanings:

(1) "**Baseline**" means the Contractor's status in effect on the effective date of its Previous Contract, primarily in light of any policies, procedures, operational or contractual arrangements or Provider arrangements, including but not limited to materials submitted during RFA 3402 as well as information submitted to OHA during the readiness review process (or a later date set by amendment to its Transformation Plan and Areas of Transformation).

(2) **"Benchmark"** means an objectively identifiable and measurable standard that the Contractor will report on to measure its progress in executing its Transformation Plan and that is the Contractor's target for the transformation area to be achieved by August 31, 2017 (or a later date set by amendment to its Transformation Plan and Areas of Transformation).

(3) **"Milestone"** means an identified incremental outcome that is both a short-term target and a logical step that moves the Contractor toward achieving its Benchmark. A Milestone may represent a stage or phase that is met on the way to achieving the Benchmark. A Milestone should be achievable on or before August 31, 2016 (or a later date set by amendment to its Transformation Plan and Areas of Transformation).

Exhibit K - Attachment 1 – Areas of Transformation

A. Benchmarks for 2015 – 2017 Transformation Plan Amendment

(1) Area of Transformation: Developing and implementing a health care delivery model that integrates mental health and physical health care and addictions and dental health, when dental services are included. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.

Benchmark 1	
How Benchmark will be measured (Baseline to July 1, 2017)	Increased number of Contractor's members, including those with serious and persistent mental illness, will have access to providers who have integrated primary care and behavioral health services through a variety of models, ranging from increased coordination to co-location to fully integrated multi-disciplinary medical homes. System of Care principles will be incoporated into the development of integrated models.
Milestone(s) to be achieved as of July 1, 2016	▪ Establish improvement target for increasing number of members served in integrated settings ▪ Identify metrics to evaluate effectiveness of integrated models in improving outcomes, such as improvement along the contiuum of integration in the Four Quadrant Clinical Integration Model ▪ Establish benchmarks and targets for implementation of alternate payment methodologies supportive of integrated models of care
Benchmark to be achieved as of July 1, 2017	▪ Increase the number of members receiving services in an integrated setting (benchmark to be developed by July 1, 2016) ▪ Monitor effectiveness of integrated models of care through identified metrics (improvement targets to be developed by July 1, 2016) ▪ Implement process to monitor increase in alternate payment methodologies used to support integrated models (target to be developed by July 1, 2016)

(2) Area of Transformation: Continuing implementation and development of Patient-Centered Primary Care Home (PCPCH).

Benchmark 2	
How Benchmark will be measured (Baseline to July 1, 2017)	Patient-Centered Primary Care Homes already serve the majority of Contractor's members (93% served by Tier 3 PCPCHs). To the extent that delivery system partners continue to refine PCPCH models, Contractor will continue to provide technical assistance to practices and support development of "advanced" medical home

	models for special populations, such as children in custody of the Department of Human Services (Foster Children) or individuals with serious and persistent mental illness.
Milestone to be achieved as of July 1, 2016	▪ Review and evaluate national and local standards for evaluating medical home models for special populations, such as behavioral health homes ▪ Identify opportunities to use alternate payment methodologies to support further development of PCPCHs and other patient-centered medical home models ▪ Establish benchmarks and targets for implementation of alternate payment methodologies in PCPCHs/medical homes
Benchmark to be achieved as of July 1, 2017	▪ Monitor implementation of alternate payment methodologies supporting PCPCHs during the life of this plan (target to be developed by July 1, 2016)

(3) Area of Transformation: Implementing consistent alternative payment methodologies that align payment with health outcomes.

Benchmark 3	
How Benchmark will be measured (Baseline to July 1, 2017)	Increase the percentage of total compensation paid to providers attributed to alternate payment methodologies. Contractor will gain a better understanding of strategies used by partner managed care entities for moving away from traditional fee-for-service payment toward paying for outcomes across a variety of payment and risk-sharing mechanisms.
Milestone to be achieved as of July 1, 2016	▪ Conduct a current state assessment of the alternate payment strategies used across managed care entities ▪ Develop a consistent method for tracking and reporting use of alternate payment methodologies for use by managed care entities ▪ Establish a baseline and develop reasonable improvement targets for increased use of alternate payment methodologies
Benchmark to be achieved as of July 1, 2017	▪ Implement process to consistently track and monitor progress toward increasing the percentage of funding dedicated to alternate payment methodologies (target to be developed by July 1, 2016)

(4) Area of Transformation: Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with ORS 414.627.

Benchmark 4	
How Benchmark will be measured (Baseline to July 1, 2017)	The Community Health Needs Assessment (CHNA) and Community Health Improvement (CHP) Plans will be completed on time and accepted by the Community Advisory Council and Board of Directors. The CHNA and CHP final dcouments are created in partnership with the Community Advisory Council.
Milestone to be achieved as of July 1, 2016	▪ Present CHP and CHNA drafts to the Community Advisory Council ▪ Report to OHA on progress accomplishing CHP strategies
Benchmark to be achieved as of July 1, 2017	▪ Submit an additional CHP report to OHA to include details on top priority health needs and progress on how disparities are being addressed in each priority area

(5) Area of Transformation: Developing a plan for encouraging electronic health records; health information exchange; and meaningful use.

Benchmark 5	
How Benchmark will be measured (Baseline to July 1, 2017)	Access to Contractor's health analytics solution will be enhanced through deployment of a user interface to support CCO and partner strategic objectives related to population management, integration of services and development of alternate payment methodologies. Data from the clinical quality measures will be incorporated into the data warehouse, providing enhanced reporting to support integrated models of care and to identify and address disparities.
Milestone to be achieved as of July 1, 2016	▪ Select and begin implementation of business analytics user interface to complement the current data warehouse ▪ Convene partners to understand their current data and analytic systems to best avoid duplication while adding intentional value ▪ Pilot use of analytics interface with a small number of provider organizations to evaluate effectiveness and benefit of user interface selected for population management purposes
Benchmark to be achieved as of July 1, 2017	▪ Expand use of busines anlaytics user interface (target to be developed by July 1, 2016)

	▪ Incorporate measures of clinical quality at the member level in data warehouse to facilitate analysis of healthcare quality across important member demograhics, including geography, race, ethnicity and language

(6) Area of Transformation: Assuring communications, Outreach, Member engagement, and services are tailored to cultural, health literacy, and linguisitic needs.

Benchmark 6	
How Benchmark will be measured (Baseline to July 1, 2017)	Contractor's Cultural Competence and Health Equity Workgroup will recommend improvements in member communications, outreach, engagement and services to ensure they are culturally and linguistically appropriate. Contractor's managed care entities participate in the Cultural Comptetence and Health Equity Workgroup with the following objectives: ▪ Develop, implement and report annual improvement plans ▪ Adopt a consistent minimum standard for policies, practices and procedures that address prioritized aspects of cultural competency ▪ Adopt a standard practice to test translated materials to improve written materials for non-English speaking members ▪ Evaluate the disparity in non-English speaking members filing complaints, grievances and appeals
Milestone to be achieved as of July 1, 2016	▪ Report to OHA documenting implementation of improvement strategies and progress on improvement measures to assure culturally and lingusitically appropriate services to members
Benchmark to be achieved as of July 1, 2017	▪ Assure that all affiliate organizations have implemented strategies and have reached minimum standards in areas identified

(7) Area of Transformation: Assuring that the culturally diverse needs of Members are met (cultural competence training, provider composition reflects Member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects Member diversity).

Benchmark 7	
How Benchmark will be measured (Baseline to July 1, 2017)	(A) Contractor will address health disparities within our membership through strategic investments in culturally specific Traditional Health Workers to improve member access to services, health care, and health outcomes.

	(B) Contractor will target resources to improve staff competence regarding equity and inclusion.
Milestone to be achieved as of July 1, 2016	(A) Develop baseline number of Community Based Organization using Traditional Health Workers: ▪ Evaluate the number of Traditional Health Worker FTE supported by Contractor and partners ▪ Develop an evaluation framework for measuring Traditional Health Worker impacts and outcomes (B) Measure the number of equity and inclusion trainings offered and the percent of staff who report an increase in knowledge and understanding of equity and inclusion issues, and establish an improvement target
Benchmark to be achieved as of July 1, 2017	(A) Develop and implement a strategic plan to invest in Traditional Health Workers to improve access to care, healthcare, and care outcomes for members: ▪ Measure percent increase in relationships between Contractor and Community Based Organizations and communities using Traditional Health Workers ▪ Implement Traditional Health Worker evaluation framework (B) Increase in number of staff self-reporting increased knowledge and understanding of issues related to equity and inclusion (Improvement target to be developed by July 1, 2016)

(8) Area of Transformation: Developing a Quality Improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

Benchmark 8	Contractor will develop an annual report of disparities analysis from a strenths-based and community-inclusive approach utilizing culturally and linguistically appropriate methods.
How Benchmark will be measured (Baseline to July 1, 2017)	▪ Convene a REaL (Race, Ethnicity and Language) data analysis group to develop and implement a strategic disparities analysis framework ▪ Analyze grievance and appeal clinical care category by race, ethnicity and language to identify disparities ▪ Provide quarterly reports and analysis to Quality Management Council
Milestone to be achieved as of July 1, 2016	▪ Develop a plan for addressing disparities using rapid cycle improvement that includes input and involvement from impacted communities

Benchmark to be achieved as of July 1, 2017	▪ Implement milestone activities with quantitative and qualitative reporting of the process and outcome measures established in improvement plans

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 available on the Contract Reports Web Site, and are by this reference incorporated into the Contract.

2. Definitions

For purposes of this Exhibit L, these terms have the following meanings:

a. **"Converted MCO"** means Contractor was determined to be a Converting MCO under the Previous Contract.

b. "**DCBS**" means Oregon Department of Consumer and Business Services, Insurance Division.

c. **"Licensed Insurer"** means a company holding a Certificate of Authority from DCBS as a health insurer or a health care service contractor.

d. "**NAIC**" means National Association of Insurance Commissioners

3. 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 4 below.

a. **Method 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, OHA will continue to monitor financial solvency utilizing similar reporting formats and financial standards that OHA used for MCOs.

b. **Method 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. Method 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.

4. Contractor Status:

The method described in Section 3 above that applies to Contractor is determined as follows:

a. If Contractor is a Converted MCO, is not a Licensed Insurer, and elected Method A-OHA Approval at its readiness review under RFA 3402, Contractor shall use Method A-OHA Approval. 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 days before the proposed effective date of change. Such changes are subject to written approval from OHA.

b. If Contractor is not a Licensed Insurer and did not elect Method A-OHA Approval at its Readiness Review under RFA 3402, Contractor shall use Method B-DCBS Approval.

c. 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 August 31st of every year, 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 Certificate of Authority is suspended or terminated.

B. Method A-OHA Approval of Solvency Plan and Financial Reporting

This Section B applies only if the Contractor uses Method A-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 Covered 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 Covered 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. Medical Loss Ratio - represents Member service expenses before reinsurance recoveries, Co-Payments, Coordination of Benefits, subrogation or other Third Party Administrator

amounts received for the OHP Line of Business, divided by total operation revenues for the OHP Line of Business.

d. **Net Premiums** - calculation obtained from Report L3.1 which represents Contractor's average OHP Capitation Rate and case rates paid (net of reinsurance premiums paid, HRA and GME payments, MMLR Rebate and Health Insurance Provider Fee) per Member during the reporting period.

e. **OHP Business** - activities Contractor performs that relate to this Contract.

f. **Quarterly Financial Reports** – financial and utilization information filed quarterly, covering the time periods defined on each report.

g. **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 through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by 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. The information specified in Report L5 shall be included in the Audited Annual Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. Amounts reported in the annual audit shall equal the amounts previously reported to OHA on Report L5 for the 4th quarter of the calendar year. Contractor shall update 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 Net Assets. The information specified in Report L6 CORP shall be included in the Audited Yearly Statement of Revenue, Expenses and Changes in Net Assets or the accompanying Notes to Financial Statements. Amounts reported in the annual audit shall equal the amounts reported to OHA on Report L6 CORP YTD for the 4th quarter of the calendar year. Contractor shall update prior Quarterly Financial Report L6 CORP 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 L7 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 Generally Accepted Accounting Principles (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 L5, L6, and L7 on the Contract Reports Web Site. Contractor shall use 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. Contractor shall make this information available to any Member upon request, with two weeks prior notice. Contractor shall also make this information available, upon request, to the Secretary of DHHS, the Inspector General of the DHHS, and the Comptroller General.

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 available 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) Report L1: General Information and Certification,

(2) Report L2: Members Approaching or Surpassing Stop-Loss Deductible,

(3) Report L3: Restricted Reserves (includes Reports L3.1 Secondary Reserve Requirement Based on Enrollment Data, L3.2 Secondary Reserve Requirement Based on Historical Expenses, and L3.3 Adjusted and Unadjusted Medical Loss Ratio: Net Worth Requirement),

(4) Report L4:Key Financial Indicators,

(5) Report L5: Quarterly Balance Sheet of Corporate Activity Corporate Total,

(6) Report L6: Quarterly Statement of Revenue, Expenses and Changes in Net Assets Corporate Total and OHP Line of Business (includes Reports L6.1 Quarterly

Statement of Administrative and Other Non-Benefit Costs and L6.2 Flexible Services,

(7) Report L7: Cash Flow Analysis Corporate Activity/Indirect Method Corporate Total,

(8) Report L8: Corporate Relationships of Contractors

OHA will,via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly Financial Reports. Contractor shall submit the Quarterly - Financial Reports to OHA using the Excel workbook supplied by OHA. Contractor shall submit the Quarterly Financial Reports to OHA through OHA's secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.

b. Contractor shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to OHA two calendar months after the end of each calendar quarter. Contractor shall submit the Quarterly Financial Reports for the 4th quarter four 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	April 30th

c. Contractor shall use GAAP to define the information requested.

d. 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 through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA, within 15 days of the date the material change is identified.

e. 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. In addition to the quarterly reports described in Section 3, Contractor shall submit annually the Audited Financial Statements as described in Section 2. If necessary, Contractor shall complete:

(1) Report L9 Audited Annual Balance Sheet of Corporate Activity

(2) Report L10 Audited Annual Statement of Revenues, Expenses & Changes in Net Assets

These reports will provide an explanation of how the Audited Financial Statements described in Section 2 above reconcile to Reports L5 and L6. Reports L9 and L10 shall

be submitted to OHA through OHA's SFTP site, or other report delivery mechanism as specified by OHA ,with the Audited Financial Statements under the timeframe described in Section 2 above.

b. Contractor shall complete Report L11 Disclosure of Compensation yearly to be uploaded with the 4th quarter submission of the Financial Reports.

c. Contractor shall complete Reports L12- L19 inclusive for use in the rate setting process to be uploaded with the 4th quarter submission of the Financial Reports

5. Assumption of Risk/Private Market Reinsurance:

Contractor assumes the risk for providing the Covered 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 Covered Services to Members.

a. Contractor shall submit Report L2 Part I, along with the Quarterly Financial Reports, due May 31st , August 31st, November 30th and April 30th. Contractor shall report Members approaching or surpassing the deductible amount of stop-loss or reinsurance. Report L2 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 first Quarterly Financial Report on May 31st, Contractor shall report to OHA on Report L2, 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 DHS or OHA.

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, and at the beginning of each year thereafter, 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 Section 6.

(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 L3 and L3.1. 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 1, less the adjustments shown on Report L6 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

Step 2: Determine the Adjusted Medical Loss Ratio (Restricted Reserve):

Member Service Expenses subtotal (Report L6- OHP, Line 17)
Less: Sub-capitation and Alternative Payment Arrangements and Salary Payments (Report L8, Part II, Columns A and C)
Divided by: Total Operating Revenue (Report L6- OHP, Line 6)

Step 3: Calculate the Average Fee-For-Service Liability. The Excel spreadsheet provided by OHA (Report L3.1) 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 L6 Quarterly Statements of Revenue, Expenses, and Changes in Net Assets 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. Contractor shall calculate the Average Fee-For-Service Liability using the Historical Method on Report L3.2 as follows:

(a) Average of: (current quarter plus 3 prior quarters) Member Service Expenses (Report L6 - OHP, Line17)

(b) Average of :(current quarter plus 3 prior quarters) Sub- capitation and Alternative Payment Arrangements (Report L8. Part II, Column C); Plus: Salary Payments (Report L8, Part 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 L3. 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 Requirement:

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 an Adjusted Annual Average Corporate Premium to Net Worth ratio less than or equal to 20:1. 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:

Average of: (current quarter plus 3 prior quarters) Total Operating Revenue (Report L6 - CORP, Line 6)

Step 2: Determine Annual Average Corporate Premium:

Average Corporate Premium
Times: four

Step 3: Determine the Adjusted Medical Loss Ratio:

Member Service Expenses Subtotal (Report L8 - OHP, Line 18)
Less: Sub-capitation and Alternative Payment Arrangements and Salary Payments (Report L8, Part II, Columns A and C)
Divided by: Total Operating Revenue (Report L6 - OHP, Line 6). If the result is less than .2000, use .2000.

Step 4: Determine Adjusted Annual Average Corporate Premium:

Annual Average Corporate Premium

Times: Adjusted Medical Loss Ratio

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 L6 and L8. If OHA determines that a Contractor's net worth ratio does not meet the required ratio level of 20:1, OHA will notify Contractor.

8. Appeal Process:

a. 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 does not meet the minimum Net Worth Requirement, OHA will notify Contractor in writing. In the event that OHA believes that the Primary or Secondary Restricted Reserve fund is inadequate, 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 the Net Worth is less than the minimum adequate level of Net Worth, 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 an Adjusted Annual Average Corporate Premium to Net Worth ratio that meets the 20:1 requirement.

b. Within 30 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 showing the Restricted Reserve balance, and/or 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, as applicable; 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 days of the Receipt of the Appeal. That decision shall be binding upon Contractor and not subject to further appeal.

c. Contractor shall submit all information to be reported under the requirements of this Section to OHA through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA.

C. Method B-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 a holding company registration statement ("Form B filing") as required by OAR 410-141-3385. 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 Covered 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 Covered 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) Covered 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.

d. Nothing in this Section 4, 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 Covered 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 Requirement:

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 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 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

D. Method C-DCBS Certificate of Authority as a Licensed Insurer Financial Reporting

This Section D applies only if the Contractor is a Licensed Insurer and follows financial reporting and solvency requirements pursuant to applicable DCBS requirements under the Oregon Insurance Code and DCBS rules.

1. Glossary of Terms

a. Corporate Activity- the financial position of a corporation relating to activities the corporation performs, including the OHP line of business. If Contractor is not a corporation, it should regard its total OHP Business as Corporate Activity.

b. OHP Business- activities Contractor performs that relate to this Contract

2. Audited Financial Statements: Contractor shall submit Audited Financial Statements to OHA through OHA's secure file transfer protocol (SFTP) site or other report deliverable mechanism as specified by 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. The information specified in Report L5 shall be included in the Audited Annual Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. Amounts reported in the annual audit shall equal the amounts previously reported to OHA on Report L5 for the 4th quarter of the calendar year. Contractor shall update 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 Net Assets. The information specified in Report L6 CORP shall be included in the Audited Yearly Statement of Revenue. Expenses and Changes in Net Assets or the accompanying Notes to Financial Statements, Amounts reported in the annual audit shall equal the amounts reported to OHA on Report L6 CORP YTD for the 4th quarter of the calendar year. Contractor shall update prior Quarterly Financial Report L6 CORP 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 L7 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 Generally Accepted Accounting Principles (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 L5, L6 and L7 on the Contract Reports Web Site. Contractor shall use 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. Contractor shall make this information available to any Member upon request, with two weeks prior notice.

Contractor shall also make this information available, upon request, to the Secretary of DHHS, the Inspector General of the DHHS, and the Comptroller General.

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 available 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) Report L1: General Information and Certification,

(2) Report L2: Members Approaching or Surpassing Stop- Loss Deductible

(3) Report L3: Restricted Reserves (includes Reports L3.1 Secondary Reserve Requirements Based on enrollment data, L3.2 secondary reserve requirements based on Historical Expenses and L3.3 Adjusted and Unadjusted Medical Loss Ratios: Net Worth Requirements.

(4) Report L4: Key Financial Indicators,

(5) Report L5: Quarterly Balance Sheet of Corporate Activity Corporate Total

(6) Report L6: Quarterly Statement of Revenue, Expenses and Changes in Net Assets Corporate Total and OHP Line of Business (includes Reports L6.1 Quarterly Statement of Administrative and Other Non-Benefit Costs and L6.2 Flexible Services)

(7) Report L7: Cash Flow Analysis Corporate Activity/Indirect Method Corporate Total.

(8) Report L8: Corporate Relationships of Contractors

OHA will, via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly Financial Reports. Contractor shall submit the Quarterly Financial Reports to OHA using the Excel workbook supplied by OHA. Contractor shall submit the Quarterly Financial Reports to OHA through OHA's secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.

b. Contractor shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to OHA two calendar months after the end of each calendar quarter. Contractor shall submit the Quarterly Financial Reports for the 4th quarter four calendar months after the end of the calendar quarter, as follows:

End of the Quarter	Due Date of Report
March 31st	May 31st
June 30th	August 31st

September 30th	November 30th
December 31st	April 30th

c. Contractor shall use GAAP to define the information requested

d. 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 through OHA's secure file transfer protocol (SFTP) site or other report deliverable mechanisms as specified by OHA, within 15 days of the date the material change is identified.

e. 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. In addition to the quarterly reports described in Section 3, Contractor shall submit annually the Audited Financial Statements as described in Section 2. If necessary, Contractor shall complete:

(1) Report L9 Audited Annual Balance Sheet of Corporate Activity

(2) Report L10 Audited Annual Statement of Revenues, Expenses & Changes in Net Asset

These reports will provide an explanation of how the Audited Financial Statements described in Section 2 above reconcile to Reports L5 and L6. Reports L9 and L10 shall be submitted to OHA through OHA's SFTP site or other report deliverable mechanisms as specified by OHA, with the Audited Financial Statements under the timeframe described in Section 2 above.

b. Contractor shall complete Report L11 Disclosure of Compensation yearly to be uploaded with the 4th quarter submission of the Financial Reports

c. Contractor shall complete Reports L12-L19 inclusive for us in the rate setting process to be uploaded with the 4th quarter submission of the Financial Reports

5. Assumption of Risk/Private Market Reinsurance:

Contractor assumes the risk for providing the Covered 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 Covered Services to Members.

a. Contractor shall submit Report L2 Part 1, along with the Quarterly Financial Reports, due May 31st, August 31st, November 30th, and April 30th, Contractor shall report Members approaching or surpassing the deductible amount of stop-loss or reinsurances. Report L2 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 first Quarterly Financial Report on May 31st. Contractor shall report to OHA on Report L2, 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.

Exhibit C-Attachment 1
CCO Specific Rates

Oregon Health Plan Medicaid Demonstration
Coordinated Care Organization Capitation Rates
January 2016 through December 2016

Plan: Health Share of Oregon
Region: TriCounty

	Base Case Rate	Base HRA Adjustment	Hospital Provider Tax Allowance	Administrative Allowance	HRA Administrative Allowance	Case Rate
Maternity Case Rate:						
Case Rate w/o Admin	$ 8,482.44	$ 2,471.74	$ 363.16	$ 737.60	$ 50.44	$ 12,105.38
Admin %						6.09%
HRA Admin %						0.42%
Non Benefit %*						9.09%

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Temporary Assistance to Needy Families - Adults**

	Capitation Rate
Base Services Rate	$337.56
Base HRA Adjustment	$49.91
Hospital Provider Tax Allowance	$11.08
Administrative Allowance	$37.43
HRA Administrative Allowance	$1.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$437.01
Services Admin %	*8.6%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Poverty Level Medical - Adults**

	Capitation Rate
Base Services Rate	$373.81
Base HRA Adjustment	$50.76
Hospital Provider Tax Allowance	$12.60
Administrative Allowance	$42.80
HRA Administrative Allowance	$1.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$481.01
Services Admin %	*8.9%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 0-1 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$471.94
Base HRA Adjustment	$155.33
Hospital Provider Tax Allowance	$20.78
Administrative Allowance	$55.48
HRA Administrative Allowance	$3.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$706.72
Services Admin %	*7.9%*
HRA Admin %	*0.4%*
Non Benefit %*	*10.8%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$117.10
Base HRA Adjustment	$17.77
Hospital Provider Tax Allowance	$3.76
Administrative Allowance	$12.80
HRA Administrative Allowance	$0.36
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$151.79
Services Admin %	*8.4%*
HRA Admin %	*0.2%*
Non Benefit %*	*10.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$128.71
Base HRA Adjustment	$12.78
Hospital Provider Tax Allowance	$3.24
Administrative Allowance	$13.97
HRA Administrative Allowance	$0.26
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$158.97
Services Admin %	*8.8%*
HRA Admin %	*0.2%*
Non Benefit %*	*10.8%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD with Medicare**

	Capitation Rate
Base Services Rate	$230.76
Base HRA Adjustment	$20.42
Hospital Provider Tax Allowance	$5.09
Administrative Allowance	$25.18
HRA Administrative Allowance	$0.42
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$281.87
Services Admin %	*8.9%*
HRA Admin %	*0.1%*
Non Benefit %*	*10.7%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD without Medicare**

	Capitation Rate
Base Services Rate	$1,198.86
Base HRA Adjustment	$217.54
Hospital Provider Tax Allowance	$41.96
Administrative Allowance	$134.83
HRA Administrative Allowance	$4.44
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,597.63
Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA with Medicare**

	Capitation Rate
Base Services Rate	$230.76
Base HRA Adjustment	$20.42
Hospital Provider Tax Allowance	$5.09
Administrative Allowance	$25.18
HRA Administrative Allowance	$0.42
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$281.87
Services Admin %	*8.9%*
HRA Admin %	*0.1%*
Non Benefit %*	*10.7%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA without Medicare**

	Capitation Rate
Base Services Rate	$1,198.86
Base HRA Adjustment	$217.54
Hospital Provider Tax Allowance	$41.96
Administrative Allowance	$134.83
HRA Administrative Allowance	$4.44
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,597.63

Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Foster Children (CAF)**

	Capitation Rate
Base Services Rate	$472.05
Base HRA Adjustment	$26.46
Hospital Provider Tax Allowance	$7.40
Administrative Allowance	$54.72
HRA Administrative Allowance	$0.54
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$561.18
Services Admin %	*9.8%*
HRA Admin %	*0.1%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 19-44**

	Capitation Rate
Base Services Rate	$319.02
Base HRA Adjustment	$41.45
Hospital Provider Tax Allowance	$9.70
Administrative Allowance	$35.27
HRA Administrative Allowance	$0.85
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$406.29

Services Admin %	*8.7%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 45-54**

	Capitation Rate
Base Services Rate	$557.02
Base HRA Adjustment	$88.44
Hospital Provider Tax Allowance	$18.07
Administrative Allowance	$62.19
HRA Administrative Allowance	$1.80
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$727.52

Services Admin %	*8.5%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 55-64**

	Capitation Rate
Base Services Rate	$581.88
Base HRA Adjustment	$99.13
Hospital Provider Tax Allowance	$19.41
Administrative Allowance	$64.94
HRA Administrative Allowance	$2.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$767.39

Services Admin %	*8.5%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-A: Physical Health, Mental Health, and Dental Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Breast and Cervical Cancer Program**

	Capitation Rate
Base Services Rate	$1,322.57
Base HRA Adjustment	$291.06
Hospital Provider Tax Allowance	$49.49
Administrative Allowance	$153.82
HRA Administrative Allowance	$5.94
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,822.87
Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Temporary Assistance to Needy Families - Adults**

	Capitation Rate
Base Services Rate	$308.22
Base HRA Adjustment	$49.91
Hospital Provider Tax Allowance	$11.08
Administrative Allowance	$34.88
HRA Administrative Allowance	$1.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$405.11
Services Admin %	*8.6%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.3%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Poverty Level Medical - Adults**

	Capitation Rate
Base Services Rate	$338.44
Base HRA Adjustment	$50.76
Hospital Provider Tax Allowance	$12.60
Administrative Allowance	$39.73
HRA Administrative Allowance	$1.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$442.56

Services Admin %	*9.0%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.8%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 0-1 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$471.57
Base HRA Adjustment	$155.33
Hospital Provider Tax Allowance	$20.78
Administrative Allowance	$55.45
HRA Administrative Allowance	$3.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$706.31
Services Admin %	*7.9%*
HRA Admin %	*0.4%*
Non Benefit %*	*10.8%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$98.20
Base HRA Adjustment	$17.77
Hospital Provider Tax Allowance	$3.76
Administrative Allowance	$11.16
HRA Administrative Allowance	$0.36
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$131.25
Services Admin %	*8.5%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.4%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$104.21
Base HRA Adjustment	$12.78
Hospital Provider Tax Allowance	$3.24
Administrative Allowance	$11.83
HRA Administrative Allowance	$0.26
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$132.33
Services Admin %	*8.9%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.4%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD with Medicare**

	Capitation Rate
Base Services Rate	$208.62
Base HRA Adjustment	$20.42
Hospital Provider Tax Allowance	$5.09
Administrative Allowance	$23.25
HRA Administrative Allowance	$0.42
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$257.79

Services Admin %	*9.0%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD without Medicare**

	Capitation Rate
Base Services Rate	$1,173.73
Base HRA Adjustment	$217.54
Hospital Provider Tax Allowance	$41.96
Administrative Allowance	$132.64
HRA Administrative Allowance	$4.44
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,570.31
Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA with Medicare**

	Capitation Rate
Base Services Rate	$208.62
Base HRA Adjustment	$20.42
Hospital Provider Tax Allowance	$5.09
Administrative Allowance	$23.25
HRA Administrative Allowance	$0.42
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$257.79

Services Admin %	*9.0%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA without Medicare**

	Capitation Rate
Base Services Rate	$1,173.73
Base HRA Adjustment	$217.54
Hospital Provider Tax Allowance	$41.96
Administrative Allowance	$132.64
HRA Administrative Allowance	$4.44
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,570.31
Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Foster Children (CAF)**

	Capitation Rate
Base Services Rate	$448.12
Base HRA Adjustment	$26.46
Hospital Provider Tax Allowance	$7.40
Administrative Allowance	$52.64
HRA Administrative Allowance	$0.54
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$535.17
Services Admin %	*9.8%*
HRA Admin %	*0.1%*
Non Benefit %*	*11.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 19-44**

	Capitation Rate
Base Services Rate	$290.16
Base HRA Adjustment	$41.45
Hospital Provider Tax Allowance	$9.70
Administrative Allowance	$32.76
HRA Administrative Allowance	$0.85
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$374.91
Services Admin %	*8.7%*
HRA Admin %	*0.2%*
Non Benefit %*	*11.3%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 45-54**

	Capitation Rate
Base Services Rate	$524.08
Base HRA Adjustment	$88.44
Hospital Provider Tax Allowance	$18.07
Administrative Allowance	$59.32
HRA Administrative Allowance	$1.80
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$691.72

Services Admin %	*8.6%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 55-64**

	Capitation Rate
Base Services Rate	$548.79
Base HRA Adjustment	$99.13
Hospital Provider Tax Allowance	$19.41
Administrative Allowance	$62.07
HRA Administrative Allowance	$2.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$731.43

Services Admin %	*8.5%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-B: Physical Health and Mental Health Services

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Breast and Cervical Cancer Program**

	Capitation Rate
Base Services Rate	$1,297.06
Base HRA Adjustment	$291.06
Hospital Provider Tax Allowance	$49.49
Administrative Allowance	$151.60
HRA Administrative Allowance	$5.94
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1,795.15
Services Admin %	*8.4%*
HRA Admin %	*0.3%*
Non Benefit %*	*11.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Temporary Assistance to Needy Families - Adults**

	Capitation Rate
Base Services Rate	$22.74
Base HRA Adjustment	$1.25
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$2.41
HRA Administrative Allowance	$0.03
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$26.43
Services Admin %	*9.1%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Poverty Level Medical - Adults**

	Capitation Rate
Base Services Rate	$12.16
Base HRA Adjustment	$1.27
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$1.34
HRA Administrative Allowance	$0.03
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$14.79
Services Admin %	*9.1%*
HRA Admin %	*0.2%*
Non Benefit %*	*9.1%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 0-1 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$0.79
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$0.07
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$0.86

Services Admin %	*8.5%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$3.11
Base HRA Adjustment	$0.01
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$0.34
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$3.46
Services Admin %	*9.9%*
HRA Admin %	*0.0%*
Non Benefit %*	*9.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$22.10
Base HRA Adjustment	$0.86
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$2.50
HRA Administrative Allowance	$0.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$25.48
Services Admin %	*9.8%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.8%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD with Medicare**

	Capitation Rate
Base Services Rate	$80.10
Base HRA Adjustment	$0.44
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$8.13
HRA Administrative Allowance	$0.01
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$88.69
Services Admin %	*9.2%*
HRA Admin %	*0.0%*
Non Benefit %*	*9.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD without Medicare**

	Capitation Rate
Base Services Rate	$132.87
Base HRA Adjustment	$8.45
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$14.26
HRA Administrative Allowance	$0.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$155.76

Services Admin %	*9.2%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA with Medicare**

	Capitation Rate
Base Services Rate	$80.10
Base HRA Adjustment	$0.44
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$8.13
HRA Administrative Allowance	$0.01
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$88.69
Services Admin %	*9.2%*
HRA Admin %	*0.0%*
Non Benefit %*	*9.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA without Medicare**

	Capitation Rate
Base Services Rate	$132.87
Base HRA Adjustment	$8.45
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$14.26
HRA Administrative Allowance	$0.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$155.76
Services Admin %	*9.2%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Foster Children (CAF)**

	Capitation Rate
Base Services Rate	$264.44
Base HRA Adjustment	$3.80
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$31.03
HRA Administrative Allowance	$0.08
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$299.35
Services Admin %	*10.4%*
HRA Admin %	*0.0%*
Non Benefit %*	*10.4%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 19-44**

	Capitation Rate
Base Services Rate	$31.06
Base HRA Adjustment	$2.06
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.27
HRA Administrative Allowance	$0.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$36.43
Services Admin %	*9.0%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 45-54**

	Capitation Rate
Base Services Rate	$36.03
Base HRA Adjustment	$1.92
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.76
HRA Administrative Allowance	$0.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$41.75
Services Admin %	*9.0%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 55-64**

	Capitation Rate
Base Services Rate	$29.89
Base HRA Adjustment	$0.77
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$2.99
HRA Administrative Allowance	$0.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$33.67
Services Admin %	*8.9%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-E: Mental Health Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Breast and Cervical Cancer Program**

	Capitation Rate
Base Services Rate	$84.52
Base HRA Adjustment	$11.79
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$8.96
HRA Administrative Allowance	$0.24
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$105.51

Services Admin %	*8.5%*
HRA Admin %	*0.2%*
Non Benefit %*	*8.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Temporary Assistance to Needy Families - Adults**

	Capitation Rate
Base Services Rate	$35.86
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.12
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$38.98
Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Poverty Level Medical - Adults**

	Capitation Rate
Base Services Rate	$38.35
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.33
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$41.69

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 0-1 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$1.00
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$0.09
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1.09

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$19.33
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$1.68
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$21.01
Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$25.18
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$2.19
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$27.37

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD with Medicare**

	Capitation Rate
Base Services Rate	$64.15
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$5.58
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$69.73

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD without Medicare**

	Capitation Rate
Base Services Rate	$57.12
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.97
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$62.09
Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA with Medicare**

	Capitation Rate
Base Services Rate	$64.15
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$5.58
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$69.73

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan:	Health Share of Oregon
Region:	TriCounty
Rate Group:	**OAA without Medicare**

	Capitation Rate
Base Services Rate	$57.12
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.97
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$62.09

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Foster Children (CAF)**

	Capitation Rate
Base Services Rate	$26.12
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$2.27
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$28.39

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 19-44**

	Capitation Rate
Base Services Rate	$38.95
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.39
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$42.34

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 45-54**

	Capitation Rate
Base Services Rate	$45.59
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$3.96
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$49.55
Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 55-64**

	Capitation Rate
Base Services Rate	$48.44
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.21
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$52.65

Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-F: Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Breast and Cervical Cancer Program**

	Capitation Rate
Base Services Rate	$57.49
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$5.00
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$62.49
Services Admin %	*8.0%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Temporary Assistance to Needy Families - Adults**

	Capitation Rate
Base Services Rate	$52.09
Base HRA Adjustment	$1.25
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.96
HRA Administrative Allowance	$0.03
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$58.33

Services Admin %	*8.5%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Poverty Level Medical - Adults**

	Capitation Rate
Base Services Rate	$47.52
Base HRA Adjustment	$1.27
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.41
HRA Administrative Allowance	$0.03
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$53.23
Services Admin %	*8.3%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.3%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 0-1 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$1.16
Base HRA Adjustment	$0.00
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$0.11
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$1.26
Services Admin %	*8.3%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.3%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 1-5 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$22.00
Base HRA Adjustment	$0.01
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$1.99
HRA Administrative Allowance	$0.00
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$24.00
Services Admin %	*8.3%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.3%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Children 6-18 (CHIP, PLMC, TANF Children)**

	Capitation Rate
Base Services Rate	$46.61
Base HRA Adjustment	$0.86
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$4.63
HRA Administrative Allowance	$0.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$52.12
Services Admin %	*8.9%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD with Medicare**

	Capitation Rate
Base Services Rate	$102.25
Base HRA Adjustment	$0.44
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$10.06
HRA Administrative Allowance	$0.01
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$112.76
Services Admin %	*8.9%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ABAD without Medicare**

	Capitation Rate
Base Services Rate	$158.01
Base HRA Adjustment	$8.45
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$16.44
HRA Administrative Allowance	$0.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$183.08

Services Admin %	*9.0%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA with Medicare**

	Capitation Rate
Base Services Rate	$102.25
Base HRA Adjustment	$0.44
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$10.06
HRA Administrative Allowance	$0.01
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$112.76
Services Admin %	*8.9%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.9%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **OAA without Medicare**

	Capitation Rate
Base Services Rate	$158.01
Base HRA Adjustment	$8.45
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$16.44
HRA Administrative Allowance	$0.17
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$183.08

Services Admin %	*9.0%*
HRA Admin %	*0.1%*
Non Benefit %*	*9.0%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Foster Children (CAF)**

	Capitation Rate
Base Services Rate	$288.37
Base HRA Adjustment	$3.80
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$33.11
HRA Administrative Allowance	$0.08
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$325.36
Services Admin %	*10.2%*
HRA Admin %	*0.0%*
Non Benefit %*	*10.2%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 19-44**

	Capitation Rate
Base Services Rate	$59.93
Base HRA Adjustment	$2.06
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$5.78
HRA Administrative Allowance	$0.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$67.80
Services Admin %	*8.5%*
HRA Admin %	*0.1%*
Non Benefit %*	*8.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 45-54**

	Capitation Rate
Base Services Rate	$68.98
Base HRA Adjustment	$1.92
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$6.63
HRA Administrative Allowance	$0.04
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$77.56

Services Admin %	*8.5%*
HRA Admin %	*0.1%*
Non Benefit %*	*8.5%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **ACA Ages 55-64**

	Capitation Rate
Base Services Rate	$62.98
Base HRA Adjustment	$0.77
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$5.87
HRA Administrative Allowance	$0.02
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$69.63

Services Admin %	*8.4%*
HRA Admin %	*0.0%*
Non Benefit %*	*8.4%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances

Oregon Health Plan Medicaid Demonstration

Coordinated Care Organization Capitation Rates

CCO-G: Mental Health and Dental Services Only

January 2016 through December 2016

Plan: Health Share of Oregon

Region: TriCounty

Rate Group: **Breast and Cervical Cancer Program**

	Capitation Rate
Base Services Rate	$110.03
Base HRA Adjustment	$11.79
Hospital Provider Tax Allowance	$0.00
Administrative Allowance	$11.18
HRA Administrative Allowance	$0.24
Health Insurers Fee	$0.00
Total Services with Admin, HRA, and HIF	$133.23
Services Admin %	*8.4%*
HRA Admin %	*0.2%*
Non Benefit %*	*8.4%*

*Non Benefit % includes Hospital Provider Tax, HIF, and Administrative Allowances