Appendix A – Definitions

For purposes of this RFA (including its Attachments and Appendices) and the resulting Contract, the terms below shall have the following meanings when capitalized. The meanings below shall apply when terms are capitalized but used with a possessive case (such as "'s" or "s'"), used in noun form when defined as a verb or vice versa, used in a phrase or with a hyphen to create a compound adjective or noun, used with a participle (such as "-ed" or "-ing"), used with a different tense than the defined term, or used in plural form when defined as singular and vice versa.

References to "they" when used in the singular or plural tense shall refer to all genders.

Terms not capitalized, whether or not listed below, shall have their commonly understood meaning and usage, including as applicable, the meaning as understood within the health care field and community.

Terms listed below used in this RFA that are not capitalized shall have the meanings listed below when the context determines the term is intended to be used with the defined meaning.

Terms defined within the text of this RFA (including its Attachments and Appendices other than this Appendix A) and the resulting Contract shall have the meanings as provided when such terms are not listed below.

"340B Drug" means a drug purchased at the prices authorized under Section 340B of the Public Health Service Act.

"340B Drug Utilization" [NEEDS DEFINITION]

"340B Entity" means a federally designated Community health center or other federally qualified covered entity that is listed on the Health Resources and Services Administration (HRSA) website.

"340B Ceiling Price" means the maximum statutory price established under section 340B (a) (1) of the Public Health Services Act.

"820 Group Premium Payment (Capitation) Transaction" [NEEDS DEFINITION]

"835 Payment/Remittance Advice Transaction" [NEEDS DEFINITION]

"ACPF" [NEEDS DEFINITION]

"AP Standard" means the standard for accurate and timely submission of all Valid Claims for a Subject Month within 45 days of the date of adjudication 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.

"AP Withhold" means an amount to be withheld for the Subject Month from Payments from OHA to Contractor and placed in an AP pool in connection with the Administrative Performance Program.

"Abuse" means improper behaviors or billing practices including, but not limited to:

Billing for a non-covered service;

Misusing codes on the claim (i.e., coding that does not comply with national or local coding guidelines or is not billed as rendered); or

Inappropriately allocating costs on a cost report.

"Action" has the meaning as provided in OAR 410-120-0000.

"Actuarial Report" is defined in the Sample Contract, Exhibit C, Section 7

"Acute" has the meaning as provided in OAR 410-120-0000.

"Acute Inpatient Hospital Psychiatric Care" means Acute care provided in an Acute Care Psychiatric Hospital.

"Acute Care Psychiatric Hospital" has the meaning as provided in OAR 309-019-0105.

"Adjudication" has the meaning provided in OAR 410-141-3000.

"Adjusted Per Capita Costs (Capitation Rates)" [NEEDS DEFINITION]

"Administrative Notice" means a notice from Contractor to OHA, or from OHA to Contractor, for purposes of administering the Contract, which meets the requirements set forth in Section 23., Paragraph b. of Exhibit D to this Contract.

"Administrative Review" means an appeal process that allows an opportunity for the Administrator of the Division of Medical Assistance Programs (Division) or their designee to review a Division decision affecting a Provider or Contractor, resulting in a final decision that is an order in other than a contested case reviewable under ORS 183.184 pursuant to the procedures in OAR 137-004-0080 to 137-004-0092.

"Administrative Performance Penalty (AP Penalty or APP)" 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.

"Adult Medicaid" [NEEDS DEFINITION]

"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 pursuant to 42 CFR 438.3(j); 42 CFR 422.128; and 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.

"Adverse Benefit Determination" has the meaning as provided in 42 CFR 438.400.

"Adverse Event" has the meaning as provided in OAR 410-120-0000.

"Advisory Committee and Executive Council" [NEEDS DEFINITION]

"Affiliate" means a person or entity that directly, or indirectly through one or more intermediaries, Controls, or is controlled by, or is under common Control with, the person or entity specified.

"Affiliated Medicare Advantage Report" [NEEDS DEFINITION]

"Aging and People with Disabilities (APD)" has the meaning as provided in OAR 410-120-0000.

"Allied Agency" has the meaning as provided in OAR 410-120-0000.

"Alternative Payment Methodology" has the meaning as provided in ORS 414.025.

"Ambulance" has the meaning as provided in OAR 410-120-0000.

"Ambulance Transportation" [NEEDS DEFINITION]

"Ambulatory Surgical Center (ASC)" has the meaning as provided in OAR 410-120-0000.

"American Indian/Alaska Native (AI/AN)" has the meaning as provided in OAR 410-120-0000.

"Ancillary Services" has the meaning as provided in OAR 410-120-0000.

"Annual FWA Assessment Report" [NEEDS DEFINITION]

"Appeal" means a review by a CCO of an Adverse Benefit Determination.

"Appeal Resolution" [NEEDS DEFINITION]

"Applicant" has the meaning as provided in OAR 410-141-3000.

"Application" has the meaning as provided in OAR 410-141-3000.

"Area Agency on Aging (AAA)" has the meaning as provided in OAR 410-120-0000.

"Areas of Transformation" [NEEDS DEFINITION]

Assertive Community Treatment (ACT)" has the meaning as provided in OAR 309-019-0105.

"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.

"Assignment" means the process by which a Client is deemed eligible to be assigned to Contractor, either in a manual or automated process.

"Assuming Contractor" [NEEDS DEFINITION]

"Authority" means the Oregon Health Authority (OHA).

"Automated Voice Response (AVR)" has the meaning as provided in OAR 410-120-0000.

"Automatic Re-enrollment" means a re-enrollment of a Member with the Contractor when the Client was Disenrolled solely because the Member loses Medicaid eligibility for a period of 2 months or less.

"Automobile Liability" [NEEDS DEFINITION]

"Baseline" for each Incentive Measure means Contractor's Baseline measurement for the Incentive Measure for the Baseline Year.

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

"Behavioral Health" has the meaning as provided in OAR 410-120-0000.

"Behavioral Health Only (BHO) Emergency Services" means health services from a qualified Provider necessary to evaluate or stabilize an emergency Behavioral 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.

"Behavioral Health Only (BHO) Member" means an individual enrolled for BHO Covered Services only. A BHO Member is 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 BHO Covered Services only (i.e. CCO-E/G).

"Behavioral Health Only (BHO) Covered Service" means those Behavioral Health services that are included in the CCO Payment paid to Contractor under the Contract with respect to a BHO Member whenever those Behavioral Health services are Medically Appropriate for the BHO Member (i.e. CCO-E/G).

"Behavioral Healthcare" [NEEDS DEFINITION]

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

"Benefit Package" has the meaning as provided in OAR 410-120-0000.

"Benefit Period" has the meaning as provided in OAR 410-141-3000.

"Breast and Cervical Cancer" [NEEDS DEFINITION]

"Breast and Cervical Cancer Program" [NEEDS DEFINITION]

"Business Day" has the meaning as provided in OAR 410-141-3000.

"Capitation Payment" means the portion of the CCO Payment paid under the Capitation Rates (as described in Sample Contract, Exhibit C, Section 6) and excludes case rate payments, maternity case rate, withholds, or any other payments paid outside the Capitation Rate.

"CCO" means Contractor for this RFA and Coordinated Care Organization for the resulting Contract unless the context determines otherwise.

"CCO Administrative Rules" means OHA's rules governing CCOs at OAR 410-141-3000 to 410-141-4120.

"CCO Payment" has the meaning as provided in OAR 410-141-3000.

"CCO Payment/Remittance Advice" [NEEDS DEFINITION]

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

"CHIPRA" [NEEDS DEFINITION]

"CMS Regional Office" [NEEDS DEFINITION]

"Care Coordinator" is a single, consistent individual who is familiar with a Member's history, strengths, needs and support system; follows a Member through transitions in levels of care, Providers, involved systems and legal status; takes a system-wide view to ensure services are unduplicated and consistent with identified strengths and needs; and who fulfills Care Coordination standards as identified in this Contract.

"Care Coordination" is a series of actions contributing to a patient-centered, high-value, high-quality care system. Care Coordination is defined as the organized coordination of Member's health care services and support activities between two or more participants deemed responsible for the Member's health outcomes and minimally includes the Member (and their family/caregiver as appropriate) and a single consistent individual in the role of care coordinator. Organizing the delivery of care and resources involves a team-based approach focused on the needs and strengths of the individual Member. The Care Coordinator insures that participants involved in a Member's care facilitate the appropriate delivery of health care services and supports. Successful Care Coordination requires the exchange of information among participants responsible for meeting the needs of the Member, explicit assignments for the functions of specific staff members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes. Successful Care Coordination is achieved when the health care team, including the Member and Family/caregiver, supported by the integration of all necessary information and resources, chooses and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for Members.

"Care Management" [NEEDS DEFINITION]

"Case Management Services" has the meaning as provided in OAR 410-120-0000.

“Charge” means the flow of funds from the Contractor to the OHA.

“Chief Executive Officer” [NEEDS DEFINITION]

“Chief Financial Officer” [NEEDS DEFINITION]

“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.

“Child Welfare (CW)” has the meaning as provided in OAR 410-120-0000.

“Children's Health Insurance Program (CHIP)” has the meaning as provided in OAR 410-120-0000.

“Citizen/Alien-Waived Emergency Medical (CAWEM)” has the meaning as provided in OAR 410-120-0000.

“Choice Area” means a Membership Service Area with more than one Contractor, if any of the Contractors does not hold a CCO contract with OHA for the 2019 Contract Year.

“Civil Commitment” means the legal process of involuntarily placing a person, determined by the Circuit Court to be a person with a mental illness as defined in ORS 426.005 (1) (f), 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.

“Claimant” has the meaning as provided in OAR 410-120-0000.

“Claims Adjudication” means Contractor’s final decision to pay claims submitted or deny them after comparing claims to the benefit or coverage requirements.

“Client” has the meaning as provided in OAR 410-120-0000.

“Clinical Record” has the meaning as provided in OAR 410-120-0000.

“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.

“CMS” is as defined internally in the contract.

“Code of Federal Regulations” [NEEDS DEFINITION]

“Cold Call Marketing” has the meaning as provided in OAR 410-141-3000.

“Community” has the meaning as provided in ORS 414.018.

“Community Advisory Council (CAC)” has the meaning as provided in OAR 410-141-3000.

“Community-Based” means services and supports provided in a Member’s home and surrounding community and not solely in a traditional office-setting.

“Co-morbid Condition” [NEEDS DEFINITION]

“Community Advisory Council (CAC)” [NEEDS DEFINITION]

“Community Health Assessment (CHA)” means a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community’s health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation.

“Community Health Improvement Plan” or “Community Improvement Plan” means a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to

set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health and defines the vision for the health of the community through a collaborative process that addresses the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community.

"Community Health Worker" has the meaning as provided in ORS 414.025.

"Community Mental Health Program (CMHP) Contested Case Hearing" has the meaning as provided in OAR 410-120-0000.

"Community Standard" has the meaning as provided in OAR 410-141-3000.

"Condition/Treatment Pairs" [NEEDS DEFINITION]

"Contested Case Hearing" means a hearing under the procedures of OAR 410-120-1860 after Contractor has upheld an Adverse Benefit Determination as provided by OAR 410-141-3240.

"Continuity of Care" [NEEDS DEFINITION]

"Contract" means a Contract awarded as a result of this RFA.

"Contract Administrator" [NEEDS DEFINITION]

"Contract Expiration Date" [NEEDS DEFINITION]

"Contract Health Services (CHS)" means a federal funding source designed to provide specialty care services to eligible Native Americans when services are unavailable at a tribal clinic.

"Contractor" means an Applicant selected through this RFA to enter into a Contract with OHA to perform the Work.

"Contractor FWA Prevention Handbook" [NEEDS DEFINITION]

"Control," including its use in the terms "controlling," "controlled," "controlled by" and "under common control with," means possessing the direct or indirect power to manage a person or set the person's policies, whether by owning voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position or corporate office the person holds.

"Coordinated Care Organization (CCO)" has the meaning as provided in OAR 410-141-3000.

"Coordinated Care Services" has the meaning as provided in OAR 410-141-3000.

"Co-Payments" has the meaning as provided in OAR 410-120-0000.

"Corrective Action or Corrective Action Plan" has the meaning as provided in OAR 410-141-3000.

"Cost Effective" has the meaning as provided in OAR 410-120-0000.

"County Health Departments" [NEEDS DEFINITION]

"Covered Services" has the meaning as provided in OAR 410-120-0000.

"Covered State Plan Services" means services eligible for payment or reimbursement under the Oregon Health Plan.

"Cultural Competence" means the same as "Cultural Awareness" as defined in OAR 309-019-0105. 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.

"Culturally Responsive" means the capacity to respond to the issues of diverse communities and requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.

"DSM-5 Diagnosis" means the diagnosis, consistent with the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), resulting from the clinical Assessment of a Member.

"DATA Waived" means Authorization from the U.S. Drug Enforcement Administration wherein physicians are qualified as practitioners (DATA Waived Provider (DWP)) pursuant to DATA (The Drug Addiction Treatment Act of 2000) and will be authorized to conduct maintenance and detoxification treatment using specifically approved schedule III narcotic medications.

"Data Submission" [NEEDS DEFINITION]

"Date of Receipt of a Claim" has the meaning as provided in OAR 410-120-0000.

"Date of Service" has the meaning as provided in OAR 410-120-0000.

"Day Treatment" [NEEDS DEFINITION]

"Declaration for Mental Health Treatment" has the meaning as provided in OAR 410-120-0000.

"Delegate" means the act of Contractor in assigning Work to a Subcontractor.

"Delegated Entities Report" [NEEDS DEFINITION]

"Delegated Subcontractor and Entities Report" is as defined internally in the contract at XXX.

"Delivery System Network"[NEEDS DEFINITION]

"Dental Care Organization (DCO)" has the meaning as provided in OAR 410-141-3000.

"Dental Care Provider" [NEEDS DEFINITION]

"Dental Services" has the meaning as provided in OAR 410-120-0000.

"Dentist" has the meaning as provided in OAR 410-120-0000.

"Department of Consumer and Business Services (DCBS)" has the meaning as provided in OAR 410-141-3000.

"Department of Human Services (Department)" has the meaning as provided in OAR 410-120-0000.

"Diagnosis Related Group (DRG)" has the meaning as provided in OAR 410-120-0000.

"Diagnostic Services" has the meaning as provided in OAR 410-120-0000.

"Disenrollment" has the meaning as provided in OAR 410-141-3000.

"Distribution Year" means the calendar year following the Measurement Year.

"Division" has the meaning as provided in OAR 410-120-0000.

"Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" has the meaning as provided in OAR 410-120-0000.

"DURP" is as defined internally in the contract at XXX.

"Dyadic Treatment" means a developmentally appropriate, evidence supported therapeutic intervention which is designed to actively engage one caregiver and one child together during the intervention to reduce symptomology in one or both participants, and to improve the caregiver-child relationship.

"ED" [NEEDS DEFINITION]

"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.

"Early Learning Council" [NEEDS DEFINITION]

"Early Learning Hubs" [NEEDS DEFINITION]

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

"Electronic Funds Transfer (EFT)" [NEEDS DEFINITION]

"Electronic Health Record (EHR)" 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.

"Emergency Dental Condition" has the meaning provided in OAR 410-120-0000.

"Emergency Department" has the meaning as provided in OAR 410-120-0000.

"Emergency Medical Condition" has the meaning as provided in OAR 410-120-0000.

"Emergency Medical Transportation" has the meaning as provided in OAR 410-120-0000.

"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.

"Emergency Services" has the meaning as provided in OAR 410-120-0000.

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

"Encounter Data Requiring Correction" [NEEDS DEFINITION]

"Encounter Pharmacy Data" means encounter claims data for Pharmaceutical Services delivered by organizations authorized to provide Pharmaceutical 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

"Enrollment" has the meaning as provided in OAR 410-141-3000.

"Enterprise FWA Prevention Handbook" [NEEDS DEFINITION]

"Episode of Care" means care that begins at treatment admission and ends at discharge. An admission has occurred if, and only if, the Client begins treatment. Events such as initial screening, Referral, and wait-listing for treatment are considered to take place before the admission to treatment and should not be considered as admission.

"Evidence-Based" means well-defined practices that are based directly on scientific evidence and that have been demonstrated to be effective through research studies.

"Exceptional Needs Care Coordination (ENCC)" has the meaning as provided in OAR 410-141-3000.

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

"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.

"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, and other EQR-related activities as set forth in 42 CFR 438.358.

"FEIN" "FWA Plan" [NEEDS DEFINITION]

"FWA Policy and Procedures" [NEEDS DEFINITION]

"FWA Reports" or "Annual FWA Assessment Report" [NEEDS DEFINITION]

"Faith-Based Organization" [NEEDS DEFINITION]

"False Claim" has the meaning as provided in OAR 410-120-0000.

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

"Family Partner" has the same meaning as Family Support Specialist as defined OAR 410-180-0305),

"Family Planning Services" has the meaning as provided in OAR 410-120-0000.

"Family Support" has the meaning as provided in OAR 309-019-0105.

"Family Support Specialist" has the meaning as provided in OAR 410-180-0305.

"Federal Medicaid Act" [NEEDS DEFINITION]

"Federally Qualified Health Center (FQHC)" has the meaning as provided in OAR 410-120-0000.

"Fee-for-Service" means a method in which doctors and other health care providers are paid for each service performed.

"Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000.

"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.

"Final Monthly Encounter Data Report" [NEEDS DEFINITION]

"Final Submission Month" means six months after the last day of the Subject Month.

"Financial Statements" [NEEDS DEFINITION]

"Four Quadrant Clinical Integration Model"

"Fraud" means the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result in some unauthorized benefit to himself or some other person(s).

"Fully Dual Eligible" has the meaning as provided in OAR 410-120-0000.

"Global Budget" has the meaning as provided in ORS 414.025.

"Governance Structure" or **"Governing Board"** means the Board of Directors or Board of Trustees of a corporation, or the comparable governing body for any other form of Legal Entity.

"Grant Award Letter" [NEEDS DEFINITION]

"**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 Adverse Benefit Determination.

"**Grievance and Appeal System"** has the meaning provided for "Grievance System" in OAR 410-141-3000.

"**Grievance and Appeal Guidebook"** [NEEDS DEFINITION]

"Grievance and Appeal Log" means the report of Grievances or complaints, and Appeals Contractor submits to OHA, using the template required by OHA and available on its contract website at: http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

"Habilitation Services" means the services set forth in OAR 410-172-0700.

"HIT Commons" [NEEDS DEFINITION]

"HIT Roadmap" [NEEDS DEFINITION]

"HPQMC Core Measure Set" [NEEDS DEFINITION]

"Health Care-Acquired Condition" has the meaning defined in 42 CFR 447.26(b).

"Health Care Professional" has the meaning as provided in OAR 410-120-0000.

"Health Equity Plan" [NEEDS DEFINITION]

"Health Evidence Review Commission" has the meaning as provided in OAR 410-120-0000.

"Health Information Exchange (HIE)" means the electronic movement of health information among disparate organizations and health information systems.

"Health Information System" [NEEDS DEFINITION]

"Health Insurance Portability and Accountability Act (HIPAA)" has the meaning as provided in OAR 410-120-0000.

"Health Promotion and Disease Prevention Activities" [NEEDS DEFINITION]

"Health System Transformation" [NEEDS DEFINITION]

"Healthcare Common Procedure Coding System (HCPCS)" has the meaning as provided in OAR 410-120-0000.

"Health-Related Services (HRS)" has the meaning as provided in OAR 410-141-3000.

"Hepatitis C DAA Drugs" means the class of direct acting antiviral (DAA) drugs to treat Hepatitis C.

"Hepatitis C DAA Expense" means encounters with a paid amount recorded for Hepatitis C DAA drugs during the Hepatitis C Risk Corridor Period.

"Hepatitis C DAA Revenue" means an amount included in the Hepatitis C DAA adjustment specified in the Contractor Rates as set forth in Attachment 1 to this Exhibit C multiplied by Contractor's Member Enrollment for the Hepatitis C Risk Corridor Period.

"Hepatitis C DAA Admin Revenue" means the administrative allowance attributed to the Hepatitis C DAA adjustment in Attachment 1 to this Exhibit C multiplied by Contractor's Member Enrollment for the Hepatitis C Risk Corridor Period.

"Hepatitis C Risk Corridor Period" means January 1, 2020 through December 31, 2020.

"Holistic Care" has the meaning as provided in OAR 410-141-3000.

"Homeless" means an individual with no fixed residential address, including individuals in shelters, are unsheltered, or who are doubled up and staying temporarily with friends or family. For more information on this definition, please refer to https://www.nhchc.org/faq/official-definition-homelessness/

"Hospice" has the meaning as provided in OAR 410-120-0000.

"Hospital" has the meaning as provided in OAR 410-120-0000.

"Hospital Adequacy Report" is as defined internally in the Contract at XXX.

"Housing-Related Services and Supports" means the services and supports that help people find and maintain stable and safe housing. Services and supports may include services at the individual level (e.g. individual assistance with a housing application process), or at the community level (e.g. community health workers stationed in affordable housing communities).

"Hysterectomy" [NEEDS DEFINITION]

"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.aspx by which Contractor's performance on each Incentive Measure is to improve during the Measurement Year by comparison with the Baseline.

"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.

"Independent Contractor" [NEEDS DEFINITION]

"Indian" [NEEDS DEFINITION]

"Indian Health Care Provider (IHCP)" has the meaning as provided in OAR 410-120-0000.

"Indian Health Service (IHS)" has the meaning as provided in OAR 410-120-0000.

"Indian Tribe" [NEEDS DEFINITION]

"Individual Service and Support Plan (ISSP)" has the meaning as provided in OAR 309-032-0311.

"Individually Identifiable Health Information" [NEEDS DEFINITION]

"Information Asset" is as defined internally in the Contract at XXX.

"Initial Procurement Expense" means expenses for physical, behavioral, dental and NEMT services including prescription drugs except for Hepatitis C DAA Drugs.

"Initial Procurement Risk Corridor Period" means January 1, 2020 through June 30, 2020.

"Initial Procurement Risk Corridor Revenue" means capitation rates for Medical Services less the amount for Hepatitis C DAA Drugs specified in the Contract Rates as set forth in Attachment 1 to this Exhibit C multiplied by Contractor's Member Enrollment for the General Risk Corridor time period.

"Initial Term" [NEEDS DEFINITION]

"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.

"Inpatient Hospital Services" has the meaning as provided in OAR 410-120-0000.

"Intensive Care Coordinator" means a person or entity providing "Intensive Care Coordination" services as defined in OAR 410-141-3170.

"Intensive Care Coordination (ICC)" has the meaning as provided in OAR 410-141-3170.

"Intensive Care Coordination Plan (ICCP)" means a collaborative, comprehensive, integrated and interdisciplinary-focused written documentation that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.

"Intensive Outpatient Services and Supports" means a specialized set of comprehensive in-home and Community-based supports and mental health treatment services, for children and youth, that are developed by the Child and Family Team and delivered in the most integrated setting in the Community.

"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.

"Intensive Treatment Services (ITS)" means the range of services delivered within a facility and comprised of Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS), Subacute and other services as determined by OHA, that provide active psychiatric treatment for children with severe emotional disorders and their families.

"Investigation of Members for Civil Commitment" [NEEDS DEFINITION]

"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 Sample Contract, Exhibit B, Part 8, Section 12.

"Laboratory" has the meaning as provided in OAR 410-120-0000.

"Laboratory Services" has the meaning as provided in OAR 410-120-0000.

"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 the Contract:

Share information about Quality Improvement;

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

Share best practices and emerging practices that increase access to Culturally Responsive and linguistically appropriate care and reduce health disparities;

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

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

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;

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

Share information and best practices on the use of Health-Related Services; and

Share information and best practices on Member engagement, education and communication.

"Legal Notice" means a notice from OHA to Contractor, or from Contractor to OHA, as described and pursuant to the requirements set forth in Exhibit D, Section 25, Paragraph a. of this Contract,

"**Liability Insurance"** has the meaning as provided in OAR 410-120-0000.

"Lien Release Template" [NEEDS DEFINITION]

"Licensed Health Entity" has the meaning as provided in OAR 410-141-3000.

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

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

For Intensive Outpatient Services and Support (IOSS) and Intensive Treatment Services (ITS) Providers, a board-certified or board-eligible child and adolescent Psychiatrist licensed to practice in the State of Oregon per OAR 309-019-0105.

"Local Community Mental Health Program (CMHP)" means a program as described in ORS 430.630.

"Liquidated Damages" means an amount of monetary damages stated in this RFA and agreed to in a resulting Contract to be the damages resulting from Contractor's non-performance of specified Contract requirements described in Exhibit B, Part 9.

“**Local Mental Health Authority (LMHA)”** has the meaning as provided in OAR 309-019-0105.

“Long Term Psychiatric Care (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.

“MAT” means Medication Assisted Treatment

“MMIS Web Portal” [NEEDS DEFINITION]

“MMLR Rebate Period” means a cumulative rolling three-year Reporting Period for the MMLR Rebate Report. The initial Rebate Period shall be for Reporting Periods 2020-2022.

“MMLR Rebate Report” means Contractor’s report of financial information required for calculating MMLR.

“MMLR Rebate” means the dollar amount which, if added to Contractor’s Total Incurred Medical Related Costs for the Rebate Period, would result in an MMLR equal to the MMLR Standard. If Contractor’s MMLR for the Rebate Period exceeds the MMLR Standard, the Rebate is zero.

“MMLR Standard” means an MMLR exceeding 85% for the Contractor’s total Member population.

“MWESB”[NEEDS DEFINITION]

“Managed Care Organization (MCO)” has the meaning as provided in OAR 410-120-0000.

“Marketing” has the meaning as provided in OAR 410-141-3000.

“Marketing Materials” has the meaning as provided in OAR 410-141-3270.

“Material Change” [NEEDS DEFINITION]

“Materials Coordinator” [NEEDS DEFINITION]

“Measurement Year” means the preceding calendar year.

“Medicaid” has the meaning as provided in OAR 410-120-0000.

“Medicaid Coverage” [NEEDS DEFINITION]

“Medicaid-Eligible Individuals” [NEEDS DEFINITION]

“Medical Assistance Program” has the meaning as provided in OAR 410-120-0000.

“Medical Case Management” [NEEDS DEFINITION]

“Medical Loss Ratio” [NEEDS DEFINITION]

“Medical Services” has the meaning as provided in OAR 410-120-0000.

“Medically Appropriate” has the meaning as provided in OAR 410-120-0000.

“Medicare” has the meaning as provided in OAR 410-120-0000.

“Medicare Advantage” has the meaning as provided in OAR 410-120-0000.

“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.

“Member Months” means Contractor’s average number of Members during a quarter, multiplied by the number of months.

“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 their parent or legal guardian.

"Member" means a Client who is enrolled with Contractor under the Contract. For all purposes in the Contract, apart from the requirements for provision of Covered Services that are limited to Behavioral Health Covered Services, a BHO Member is a Member of the CCO.

"Membership Service Area" means:

For a county in which OHA did not award any Contractor a Service Area of less than all of the county: the whole county; and

For a county in which OHA did award any Contractor a Service Area of less than all of the county: the part of county awarded as the Service Area, and separately the part of the county not awarded as the Service Area.

"Memoranda of Understanding" [NEEDS DEFINITION]

"Mental Health Organization (MHO)" has the meaning as provided in OAR 410-141-3000.

"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.

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

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

"Minimum Medical Loss Ratio (MMLR)" [NEEDS DEFINITION]

"Mobile Crisis Services" has the meaning as provided in OAR 309-019-0105.

"**NAIC**" means National Association of Insurance Commissioners.

"NQTL"[NEEDS DEFINITION]

"National Correct Coding Initiative (NCCI)" has the meaning as provided in OAR 410-120-0000.

"National Drug Code (NDC)" [NEEDS DEFINITION]

"National Practitioner Data Bank" [NEEDS DEFINITION]

"National Provider Identifiers (NPIs)" [NEEDS DEFINITION]

"Neuropsychiatric Treatment Service (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.

"Non-Covered Services" has the meaning as provided in OAR 410-120-0000.

"Non-Emergent Medical Transportation Services (NEMT)" has the meaning as provided in OAR 410-120-0000.

"Non-Participating Indian Health Care Providers" [NEEDS DEFINITION]

"Non-Participating Provider" has the meaning as provided in OAR 410-141-3000.

"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.

"Notice of Adverse Benefit Determination Notice (NOABD)" means written notice that satisfies the requirements as described in OAR 410-141-3240.

"Notice of Appeal Resolution" means Contractor's notification to a Member of the resolution of an Appeal as described in OAR 410-141-3247.

"Nurse Practitioner" has the meaning as provided in OAR 410-120-0000.

"Nursing Facility" has the meaning as provided in OAR 410-120-0000.

"OEBB" means the Oregon Educators Benefit Board within OHA.

"Office of Contracts and Procurement (OC&P)" means the office that is responsible for the procurement and contracting process for OHA.

"OHP" means Oregon Health Plan.

"OHPB" means the Oregon Health Policy Board.

"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. Offsets are calculated on an accrual basis.

"Open Enrollment" means a period where Members who reside in a Choice Area may make changes to their CCO Enrollment.

"Oregon Administrative Rules" [NEEDS DEFINITION]

"Oregon Health Authority," "Authority" or "OHA" has the meaning as provided in OAR 410-120-0000.

"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.

"Oregon Patient/Resident Care System (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.

"Oregon Revised Statutes" [NEEDS DEFINITION]

"Oregon State Medicaid Plan" [NEEDS DEFINITION]

"Oregon State Public Health Laboratory (OSPHL)

"Oregon Tax Laws" is as defined internally in the Contract at XXX.

"Oregon Youth Authority (OYA)" has the meaning as provided in OAR 410-120-0000.

"OSH" means Oregon State Hospital.

"Outreach" has the meaning as provided in OAR 410-141-3270.

"Outreach Marketing Materials" [NEEDS DEFINITION]

"Outreach Materials" has the meaning as provided in OAR 410-141-3270.

"Overpayment" means any amount by which the Authority has paid monies to Contractor to which Contractor was not entitled at the time of payment or to which Contractor is no longer entitled.

"Participating Provider" has the meaning as provided in OAR 410-141-3000.

"Parties" is as defined internally in the Contract at XXX.

"Patient Protection and Affordable Care Act (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).

"Patient-Centered Primary Care Home (PCPCH)" means a health care team or clinic as defined in ORS 414.025(19), which meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

"Payment" means the flow of funds from OHA to Contractor.

"PAHP" [NEEDS DEFINITION]

"PEBB" means the Public Employees Benefit Board within OHA.

"PIHP" [NEEDS DEFINITION]

"Peer" has the meaning as provided in OAR 309-019-0105.

"Peer-Delivered Services" has the meaning as provided in OAR 309-019-0105.

"Peer Support Specialist" has the meaning as provided in OAR 309-019-0105.

"Peer Wellness Specialist" has the meaning as provided in OAR 309-019-0105.

"Peer-Delivered Services (PDS)" has the meaning as provided in OAR 309-019-0105.

"Person" [NEEDS DEFINITION]

"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 410-172-0780.

"Personal Health Navigator" has the meaning as provided in ORS 414.025.

"Personal Injury Liens" [NEEDS DEFINITION]

"Pharmaceutical Services" has the meaning as provided in OAR 410-120-0000.

"Pharmacy Benefit Manager (PBM)" [NEEDS DEFINITION]

"Pharmacy Data Requiring Correction" is as defined internally in the Contract at XX.

"Physical Care Provider" [NEEDS DEFINITION]

"Physician" has the meaning as provided in OAR 410-120-0000.

"Physician Assistant" has the meaning as provided in OAR 410-120-0000.

"Physician Incentive Plans" [NEEDS DEFINITION]

"Post Hospital Extended Care (PHEC) Coordination" is as defined internally in the Contract at XX.

"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.

"Potential Member" has the meaning as provided in OAR 410-141-3000.

"Practice Level Workgroup" [NEEDS DEFINITION]

"Practitioner" has the meaning as provided in OAR 410-120-0000.

"Preadmission Screeening and Resident Review (PASRR)"[NEEDS DEFINITION]

"Preferred Drug List (PDL)" [NEEDS DEFINITION]

"Prepaid Health Plan (PHP)" has the meaning as provided in OAR 410-120-0000.

"Prevention" [NEEDS DEFINITION]

"Primary Care Provider (PCP)"

"Prior Contract" or "Previous Contract" means Contractor's contract with OHA for Coordinated Care Services that expired immediately before the Effective Date of the Contract.

"Prior Authorization (PA)" has the meaning as provided in OAR 410-120-0000.

"Prioritized List of Health Services" has the meaning as provided in OAR 410-120-0000.

"Prioritized Populations" means individuals with SPMI, children 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis, individuals in medication assisted treatment for SUD, pregnant women and parents with dependent children, children with neonatal abstinence syndrome, children in Child Welfare, IV drug users, individuals with SUD in need of withdrawal management, individuals with HIV/AIDS, individuals with tuberculosis, Veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the I/DD population, and other prioritized members.

"Provider" has the meaning as provided in OAR 410-120-0000.

"Provider Organization" has the meaning as provided in OAR 410-120-0000.

"Provider Overpayment" means a payment made by the Authority or Contractor to a Provider in excess of the correct payment amount for a service.

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

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

"Provider Termination" means the termination of Provider's contract with Contractor, or a prohibition of Provider's participation in OHA Health Services Division programs as provided by OAR 410-120-0000,

"Psychiatric Day Treatment Services (PDTS)" means the comprehensive, interdisciplinary, non-residential, Community-based program consisting of psychiatric treatment, Family treatment and therapeutic activities integrated with an accredited education program.

"Psychiatric Residential Treatment Service (PRTS)" has the meaning defined in OAR 410-172-0010.

"Psychiatrist" has the meaning as provided in OAR 309-019-0105.

"Psychologist" has the meaning as provided in OAR 309-019-0105.

"QA/PI" or "QAPI" is as internally defined in the Contract at XXX.

"Qualified Medicare Beneficiary (QMB)" has the meaning as provided in OAR 410-120-0000.

"Qualified Mental Health Associate (QMHA)" has the meaning as provided in OAR 309-019-0105.\

"Qualified Mental Health Professional (QMHP)" has the meaning as provided in OAR 309-019-0105.

"Quality"[NEEDS DEFINITION]

"Quality Assurance and Performance Improvement Program (QAPI)"

"Quality Improvement" has the meaning as provided in OAR 410-120-0000.

"Quality Measure" has the meaning as provided in ORS 414.025.

"Quality Pool" means dollar amounts that OHA will pay CCOs as incentives for performance on Incentive Measures specified in the Exhibit C.

"Quarterly FWA Report" [NEEDS DEFINITION]

"Race, ethnicity, preferred spoken and written languages and disability status standards" or "REAL+D standards)" means standards under ORS 413.161.

"Readiness Review" means a determination by OHA that an Applicant or CCO is qualified to hold a CCO Contract.

"Receiving CCO" or "Receiving Contractor" means the CCO that is receiving Members during the Open Enrollment period who were previously enrolled with another CCO in 2019.

"Recipient" has the meaning as provided in OAR 410-120-0000.

"Record Keeping" [NEEDS DEFINITION]

"Recoup" or "Recoupment" and all other forms of such term means the recovery of sums owed by one party ("First Party") to the other party ("Second Party"). In such event, the sums subject to recovery shall be made by withholding all or a portion of future payments that may be owed by the Second Party to the First Party from those sums owed to the First Party by the Second Party.

"Recovery Amount" [NEEDS DEFINITION]

"Referral" has the meaning as provided in OAR 410-120-0000.

"Region" has the meaning as provided in ORS 414.018.

"Remittance Advice (RA)" has the meaning as provided in OAR 410-120-0000.

"Renew," "Renewal" or "Renewed" means an agreement by the Authority and Contractor to amend the terms or conditions of the Contract for the next Benefit Period. "Renew" does not include expiration of the Contract followed by a successor contract.

"Renewal Contract" means either: (1) a Rate Amendment described in Sample Contract, Exhibit C, Section 11; or (2) an amendment extending this term of the Contract.

"Representative" means a Member's Community Health Worker, foster parent, adoptive parent, or other Provider delegated with the authority to represent a Member, as well as any person within the meaning provided by OAR 410-141-0000.

"Request for Applications (RFA)" has the meaning as provided in OAR 410-141-3000.

"Request for Hearing" has the meaning as provided in OAR 410-120-0000.

"Restricted Reserve Account" [NEEDS DEFINITION]

"Risk Corridor Period" is as defined internally in the Contract at XXX.

"Roadmap Categorization Guidance"[NEEDS DEFINITION]

"Rural" has the meaning as provided in OAR 410-120-0000.

"Sanction" means an action taken by Contractor against a Provider or Subcontractor, or by the Authority against Contractor, in cases of fraud, waste, abuse, or violation of contractual requirements.

"Sanctioned"[NEEDS DEFINITION]

"School Based Health Service" has the meaning as provided in OAR 410-120-0000.

"SRTF" means Secure Residential Treatment Facility.

"Serious and Persistent Mental Illness (SPMI)" has the meaning defined in OAR 309-036-0105.

"Service Area" has the meaning as provided in OAR 410-141-3000.

"Service Authorization Request" is as defined internally in the Contract at Exhibit B, Part 9, Section 9, Paragraph b., subparagraph h.

"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.

"Signature Authorization Form" [NEEDS DEFINITION]

"Skilled Nursing Facility Care" [NEEDS DEFINITION]

"Social Determinants of Health and Health Equity (SHOH-HE)" means as follows: **SDOH** means the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social determinants of health include, but are not limited to: Poverty, education, employment, food insecurity, diaper insecurity, housing, access to quality child care, environmental conditions, trauma/adverse childhood experiences, and transportation. **SDOHE** means the Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. Institutional racism is one example. Together **SDOH-HE** is the combined factors of the social determinants of health and the social determinants of health equity.

"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, 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), or 3) are a Member of the Prioritized Populations listed in the Contract.

"State" means the State of Oregon.

"State Facility" has the meaning as provided in OAR 410-120-0000.

"Statewide Supplemental Rebate Agreement" means an agreement entered into by OHA with a prescription drug manufacturer for a pricing agreement /or rebate agreement, or combination thereof, with requirements regarding dispensing criteria, preferred drug list placement, or Prior Authorization criteria. OHA will provide Contractor a list of the provisions applicable to Contractor as contained within the Statewide Supplemental Rebate Agreement to ensure consistent application of the provisions contained therein by all CCOs. OHA will provide Contractor 60 days' prior written notice of the applicable Statewide Supplemental Rebate Agreement provisions.

"Sterilization" [NEEDS DEFINITION]

"Strategy and Areas of Transformation" [NEEDS DEFINITION]

"Subcontract" means either (i) a contract between Contractor and Subcontractor to which such Subcontractor is obligated to perform certain Work that is otherwise required to be performed by

Contractor, or (ii) is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning certain Work required to be performed by Contractor under this Contract to a Subcontractor.

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

"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.

"Submit" means to transfer reports or other information from Contractor to OHA in accordance with Exhibit D, Section 25, Paragraph c. of this Contract.

"Subrogation" has the meaning as provided in OAR 410-120-0000.

"Substance Use Disorders Provider" means a Practitioner approved by OHA to provide Substance Use Disorders services.

"Substance Use Disorders (SUDs)" 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-V criteria.

"Supplemental Security Income (SSI)" has the meaning as provided in OAR 410-120-0000.

"Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.

"Supported Housing" is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in Supported Housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. People have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported Housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported Housing is scattered site housing. To be considered Supported Housing, for buildings with two or three units, no more than one unit may be used to provide Supported Housing for people with SPMI who are referred by OHA or it contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide Supported Housing for people with SPMI who are referred by OHA or it contractors. Supported Housing has no more than two people in a given apartment or house, with a private bedroom for each individual. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported Housing does not include housing where providers can reject individuals for placement due to medical needs or substance abuse history.

"Surgical Assistant" has the meaning as provided in OAR 410-120-0000.

"Suspension" has the meaning as provided in OAR 410-120-0000.

"System of Care (SOC)" means a coordinated network of services and supports, including education, Child Welfare, public health, primary care, pediatric care, juvenile justice, Behavioral 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 Responsive 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 a supportive policy and management infrastructure.

"TPLR Policy" [NEEDS DEFINITION]

“Team Facilitation” means the process of working with the Child and Family Team in developing a unified plan of care.

“Telemedicine” [NEEDS DEFINITION]

“Term” [NEEDS DEFINITION]

“Therapeutic Foster Care” [NEEDS DEFINITION]

“Third Party Liability (TPL),” “Third Party Resource (TPR),” or **“Third Party Payer”** have the meaning provided in OAR 410-120-0000.

“Title XIX of the Social Security Act” [NEEDS DEFINITION]

“Traditional Health Worker (THW)” has the meaning defined in OAR 410-180-0305.

“Trauma Informed” means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.

“Transition Plan” [NEEDS DEFINITION]

“Transferring CCO” means the CCO that is transferring Members during the Open Enrollment period to another CCO, because of 2019 contract termination, Member choice or auto Assignment.

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

“Treatment Plan” has the meaning as provided in OAR 410-141-3000.

“Triage Urgent Care” [NEEDS DEFINITION]

“Tribal Organization” [NEEDS DEFINITION]

“Tribes” means Oregon’s nine federally recognized Tribes and, as the context requires, includes Oregon’s Urban Indian Health Program.

“Type A Hospital” has the meaning as provided in OAR 410-120-0000.

“Type B AAA” has the meaning as provided in OAR 410-120-0000.

“Type B Hospital” has the meaning as provided in OAR 410-120-0000.

“Urban” has the meaning as provided in OAR 410-120-0000.

“Urban Indian Organization” [NEEDS DEFINITION]

“Urgent Care Services” has the meaning as provided in OAR 410-120-0000.

“Usual Charge (UC)” has the meaning as provided in OAR 410-120-0000.

“Utilization Review (UR)” has the meaning as provided in OAR 410-120-0000.

“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).

“Valid Encounter Data” means Encounter Data that comply with OAR 410-141-3430.

“Value-Based Payment (VBP)” means payment to a Provider that explicitly rewards the value that can be produced through the provision of health care services to CCO Members. VBP categories include, but are not limited to:

Foundational Payments for Infrastructure and Operations;

Pay for Reporting;

Rewards for Performance/Penalties for Performance;

Shared savings;

Shared risk;

Partial Capitation or Episode-based Payments;

Comprehensive Population-based Payment; and

Integrated Finance and Delivery System.

"Warm Handoff" means the process of transferring a Client from one Provider to another in a Culturally Responsive manner, honoring the Member's choice. A Warm Handoff includes face-to-face meeting(s) with the Client prior to discharge or transition between Providers, and which coordinates the transfer of responsibility for the Client's ongoing care and continuing treatment and services.

"Waste" means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.

"Web" [NEEDS DEFINITION]

"Withhold" means to designate a portion of a Payment from OHA to Contractor to apply toward an amount owed by Contractor to OHA, or to delay all or part of a Payment to Contractor under conditions authorized by the Contract.

"Withhold Month" means the month in which an APP will be applied to a Capitation Payment.

"Work" means the required activities, obligations, tasks, deliverables, reporting, and invoicing requirements, as described in Section 3-Scope of Work of this RFA and in the Sample Contract.

"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.

"Wraparound Review Committee" reviews and selects entering Wraparound clients according to locally established criteria. Referral information will be collated by the Referral source and communicated to the review committee through the Coordinated Care Organization. The review committee will include young adult/youth and families or Family/Youth Partners on a team of cross-system stakeholders that review Referrals of Wraparound Assessment and screening information, to ensure shared decision making. The review committee will assist in the management of the targeted number of participants, analyzing the types and mix of Referrals, and looking for patterns and disparities in Referrals. Federal level confidentiality standards applicable to all involved systems will be maintained. Transitions out of SOCWI(System of Care Wraparound Initiative) will be reviewed to ensure maximal opportunity for incoming Referrals to be served.

"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.

"Year 1" means 2020. Years 2 through 5 mean 2021 through 2024.

"Young Adult Peer Support" [NEEDS DEFINITION]

"Youth Development Council" [NEEDS DEFINITION]

"Youth Partner" has the same meaning as Youth Support Specialist.

"Youth Support Specialist" has the meaning as provided in OAR 410-180-0305.