



OREGON HEALTH PLAN

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # xxxxxxxx

with

xxxxxxx

Table of Contents

I. <u>I.</u> Effective Date and Duration	7
II. Contract in its Entirety	8
III. Vendor or Sub-Recipient Determination	8
IV.	
<u>2.</u> Status of Contractor	9
V. <u>3.</u> Enrollment Limits and Service Area	9
VI. <u>4.</u> Interpretation and Entire Contract; Administration of Contract <u>9: Interpretation of Contract</u>	10
VII	
<u>4.1 Entire Contract</u>	10
<u>4.2 Administration of Contract</u>	10
<u>4.3 Interpretation of Contract</u>	10
<u>5.</u> Contractor Data and Certification	11 <u>13</u>
VIII.	
<u>5.1 Certification and Acknowledgement</u>	14
<u>5.3 Signatures</u>	13 <u>15</u>
Exhibit A - Definitions	14 <u>16</u>
Exhibit B – Statement of Work - Part 1 – Governance and Organizational Relationships	15 <u>17</u>
1. Governing Board and Governance Structure	15 <u>17</u>
2. Clinical Advisory Panel	15 <u>17</u>
3. Innovator Agent and Learning Collaborative	15 <u>17</u>
Exhibit B – Statement of Work - Part 2 – Covered and Non-Covered Services	16 <u>18</u>
1. Covered Services	16 <u>18</u>
2. Provision of Covered Service	16 <u>18</u>
3. Authorization or Denial of Covered Services	18 <u>20</u>
4. Covered Service Components <u>20 Component: Crisis, Urgent and Emergency Services</u>	18 <u>20</u>
<u>23</u>	
5.	
<u>5. Covered Service Component: Non-Emergent Medical Transportation (NEMT)</u>	24
<u>6. Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care</u>	33
<u>7. Covered Service Components: Medication Management</u>	35
<u>8. Covered Service Components: Other Services</u>	37
<u>9. Non-Covered Health Services with Care Coordination</u>	31 <u>39</u>
<u>610. Non-Covered Health Services without Care Coordination</u>	32 <u>40</u>
Exhibit B –Statement of Work - Part 3 – Patient Rights and Responsibilities, Engagement and Choice	33 <u>41</u>
1. Member and Member Representative Engagement and Activation <u>33 in Member Health Care and Treatment Plans</u>	41 <u>41</u>
2. Member Rights under Medicaid	33 <u>41</u>
3. Provider’s Opinion	35 <u>44</u>
4. Informational Materials and Education of <u>for Members and Potential Members</u> 35: General Information and Education	35 <u>44</u>
5.	
<u>5. Informational Materials for Members and Potential Members: Member Handbook</u>	46
<u>6. Informational Materials for Members and Potential Members: Provider Directory</u>	47
<u>7. Grievance <u>and Appeal</u> System</u>	37 <u>49</u>

6 . Enrollment <u>49</u>	
<u>9</u> . and Disenrollment	<u>3750</u>
7 .	
<u>10</u> . Member Benefit Package Changes	<u>52</u>
<u>11</u> . Enrollment Reconciliation	<u>52</u>
<u>12</u> . Identification Cards	<u>4253</u>
8 <u>13</u> . Marketing to Potential Members	<u>4253</u>
9 . Member Communications	<u>43</u>
<u>14</u> . Onboarding of Members Prior to Effective Date of Coverage	<u>54</u>
Exhibit B –Statement of Work - Part 4 – <u> Providers and Delivery System</u>	<u>4458</u>
1. Integration and Coordination	<u>4458</u>
2. Access to Care	<u>4459</u>
3. Delivery System and Provider Capacity	<u>4763</u>
4. Provider Workforce Development	<u>4864</u>
5. Provider Selection	<u>4865</u>
6. Credentialing	<u>4966</u>
7. Patient Centered Primary Care Homes (PCPCH)	<u>5169</u>
8. Care Coordination	<u>5370</u>
9. Care Integration	<u>5471</u>
10. Delivery System Dependencies	<u>5572</u>
11. Evidence-Based Clinical Practice Guidelines	<u>5674</u>
12 . Health Promotion and Prevention	<u>56</u>
13 .	
<u>12</u> . Subcontract Requirements	<u>5774</u>
14 <u>13</u> . Minority-Owned, Woman-Owned and Emerging Small Business (“MWESB”) Participation	<u>79</u>
14 . 60	
15 . Adjustments in Service Area or Enrollment	<u>6079</u>
<u>Exhibit B, Parts 5 through 7 are reserved</u>	<u>82</u>
Exhibit B –Statement of Work - Part 8 – Operations	<u>64</u>
1 . Accountability and Transparency of Operations	<u>6483</u>
<u>1</u> . Record Keeping Requirements	<u>83</u>
2. Privacy, Security, and Retention of Records	<u>6584</u>
<u>3</u> . Access to Records	<u>84</u>
4. Payment Procedures	<u>6685</u>
5. Claims Payment	<u>6786</u>
6. Medicare Payers and Providers	<u>6988</u>
7. Eligibility Verification for Fully Dual Eligible Members	<u>6989</u>
8. All Payers All Claims (APAC) Reporting Program	<u>7089</u>
9. Administrative Performance Program 70 : <u>Valid Encounter Claims Data</u>	<u>90</u>
10. Encounter Claims -Data 71 : <u>Submission Processes</u>	<u>92</u>
12 <u>11</u> . Encounter Claims -Data: (Non-Pharmacy) 73 – <u>Additional Requirements</u>	<u>92</u>
13 <u>12</u> . Encounter Pharmacy Data	<u>7393</u>
<u>13</u> . Administrative Performance Standard	<u>93</u>
14. Drug Rebate Program	<u>7494</u>
<u>15</u> . Drug Rebate Dispute Resolution Process	<u>95</u>
16. Third Party Liability (“TPL”) and Personal Injury Liens	<u>7595</u>

17. Personal Injury Lien (“PIL”)	98
18. Disclosure of Ownership Interest	78 Interests
102	
19. Upon renewal or extension of the Contract	79
20.	
19. Disclosure of Other Ownership Interests	103
20. Certain Changes in Ownership Requiring Pre-Approval from OHA	103
21. Subrogation	80 105
21. Contractor’s Board of Directors	80
Exhibit B –Statement of Work - Part 9 – Program Integrity	81 106
1. Monitoring and Compliance Review 81 - Overview	106
2. Conditions that may Result in Sanctions	81 106
3. Range of Sanctions Available	83 108
4.	
4. Amount of Civil Money Penalties: 42 CFR §438.704	108
5. Temporary Management	109
6. Corrective Action Plan	84 110
5. Liquidated Damages	85
6. Intermediate Sanctions	86
7.	
7. Civil Money Penalties: OAR 410-141-3259	110
8. Sanction Process	87 112
89. Notice to CMS of Contractor Sanction	88 112
9. Compliance Plan	88
10.	
10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures	112
11. Contractor’s Fraud, Waste, and Abuse Prevention Policies and Procedures	113
13. Review and Approval of Fraud, Waste, and Abuse Handbooks	116
14. OHA & Contractor Audits of Network Providers	117
15. Documenting and Processing Contractor Recovery of Overpayments Made to Third Parties	117
16. Examples of Fraud, Waste, and Abuse	118
17. Obligations to Report Fraud, Waste and Abuse: Policies and Procedures	119
18. Assessment of Compliance Activities	89 121
11. Fraud Waste and Abuse Policies	90
12. Review of Compliance Plan and Fraud, Waste and Abuse Policies	91
13. Treatment of Overpayment Recoveries Due to Fraud, Waste and Abuse	91
14. Audits of Network Providers	92
15. Referral Policy	92
16. Reporting Fraud, Waste and Abuse	93
Exhibit B –Statement of Work - Part 10 – Quality, - Transformation Reporting , Performance Outcomes Measures and Accountability	96 External Quality Review 123
1. Overview	96 123
2. Transformation and Quality Strategy Requirements	96 123
3. Revised Transformation and Quality Strategy	97
4. Transformation and Quality Strategy Monitoring and Compliance Review	97
5. Transformation and Quality Strategy Deliverables	98
6. Goals for Transformation and Quality Strategy Amendments	98

7. Quality and Performance Outcomes	98
8. Performance Measurement and Reporting Requirements	98
9. Quality	
<u>3. Performance Measures</u>	<u>125</u>
<u>4. Performance Measures: Quality Pool Incentive Payments</u>	<u>126</u>
<u>5. Performance Measure Incentive Payments for Participating Providers</u>	<u>128</u>
<u>6. Performance Improvement Projects</u>	99 <u>128</u>
10. Program Requirements	100
11	
<u>7. Additional Health System Transformation Obligations</u>	<u>129</u>
<u>8. External Quality Review</u>	100 <u>130</u>
12. Quality Pool	101
Exhibit C – Consideration	104 <u>132</u>
1. Payment Types and Rates	104 <u>132</u>
2. Payment in Full	104 <u>133</u>
3. Changes in Payment Rates	104 <u>133</u>
4. Timing of CCO Payments	105 <u>134</u>
5. Settlement of Accounts	106 <u>135</u>
6. CCO Risk Corridor	108 <u>Corridors</u>
<u>136</u>	
7. Global Payment Rate Methodology	111 <u>138</u>
8. Administrative Performance Penalty	111 <u>139</u>
9. Quality Pool	111 <u>139</u>
10. Minimum Medical Loss Ratio:	111 <u>139</u>
Exhibit C – Consideration - Attachment 1 – CCO Payment Rates	113 <u>141</u>
Exhibit D – Standard Terms and Conditions	114 <u>142</u>
1. Governing Law, Consent to Jurisdiction	114 <u>142</u>
2. Compliance with Applicable Law	114 <u>142</u>
3. Independent Contractor	115 <u>143</u>
4. Representations and Warranties	115 <u>143</u>
5. (Reserved)	115
<u>5. Correction of Deficient Documents</u>	<u>143</u>
6. Funds Available and Authorized; Payments	115 <u>144</u>
7. Recovery of Overpayments 116 <u>or Other Amounts Owed by Contractor</u>	<u>144</u>
8. Indemnity	116 <u>144</u>
9. Default; Remedies; and Termination	117 <u>145</u>
10.	
<u>10. Effect of Legal Notice of Termination, Non-Renewal, or Failure to Renew: Transition Plan</u>	<u>150</u>
<u>11. Effect of Termination or Expiration: Other Rights and Obligations</u>	<u>152</u>
<u>12. Limitation of Liabilities</u>	124 <u>154</u>
11 <u>13. Insurance</u>	124 <u>154</u>
12.	
<u>14. Transparency: Public Posting of Contractor Reports</u>	<u>154</u>
<u>15. Access to Records and Facilities</u>	124 <u>155</u>
13 <u>16. Information Privacy/Security/Access</u>	125 <u>155</u>
14 <u>17. Force Majeure</u>	125 <u>156</u>
15 <u>18. Foreign Contractor</u>	126 <u>156</u>

16 <u>19</u> . Assignment of Contract, Successors in Interest	126 <u>156</u>
17 <u>20</u> . Subcontracts	126 <u>156</u>
18 <u>21</u> . No Third Party Beneficiaries	126 <u>157</u>
19 <u>22</u> . Amendments	126 <u>157</u>
20 <u>23</u> . Waiver	127 <u>158</u>
21 <u>24</u> . Severability	127 <u>158</u>
22 <u>25</u> . Survival	127 <u>158</u>
23 . Notices	129
24	
25 . <u>Legal Notice; Administrative Notice</u>	130 <u>160</u>
26 <u>27</u> . Construction	130 <u>161</u>
25 <u>28</u> . Headings	130 <u>161</u>
26 <u>29</u> . Merger Clause	130 <u>161</u>
27 <u>30</u> . Counterparts	130 <u>161</u>
28 <u>31</u> . Equal Access	130 <u>162</u>
29 <u>32</u> . Media Disclosure	130 <u>162</u>
30 <u>33</u> . Mandatory Reporting 130 <u>of Abuse</u>	162
Exhibit E - Required Federal Terms and Conditions	131 <u>163</u>
1. Miscellaneous Federal Provisions	131 <u>163</u>
2. Equal Employment Opportunity	131 <u>163</u>
3. Clean Air, Clean Water, EPA Regulations	131 <u>163</u>
4. Energy Efficiency	132 <u>164</u>
5. Truth in Lobbying	132 <u>164</u>
6. HIPAA Compliance	133 <u>165</u>
7. Resource Conservation and Recovery	134 <u>166</u>
8. Audits	134 <u>166</u>
9. Debarment and Suspension	134 <u>166</u>
10. Pro-Children Act	135 <u>167</u>
11. Additional Medicaid and CHIP	135 <u>167</u>
12. Agency-based Voter Registration	135 <u>167</u>
13. Clinical Laboratory Improvements	135 <u>Improvement</u>
<u>167</u>	
14. Advance Directives	136 <u>168</u>
15. Practitioner Incentive Plans (PIP)	136 <u>168</u>
16. Risk HMO	136 <u>168</u>
17. Conflict of Interest Safeguards	136 <u>168</u>
18. Non-Discrimination	138 <u>170</u>
19. OASIS	138 <u>170</u>
20. Patient Rights Condition of Participation	138 <u>170</u>
21. Federal Grant Requirements	138 <u>170</u>
22. Mental Health Parity	138 <u>171</u>
Exhibit F – Insurance Requirements	140 <u>173</u>
<u>1. Workers’ Compensation</u>	173
<u>2. Professional Liability</u>	173
<u>3. Commercial General Liability</u>	173
<u>4. Automobile Liability</u>	173
<u>5. Additional Insured</u>	174

6. Administrative Notice of Cancellation or Change	174
7. Proof of Insurance	174
8. “Tail” Coverage	174
9. Self-insurance	174
Exhibit G – Reporting of Delivery System Network <u>Netwrok</u> Providers, Cooperative Agreements, and Hospital Adequacy	142 <u>175</u>
1. Delivery System Network (DSN) <u>Reports</u>	142 <u>Provider Monitoring and Reporting Overview 175</u>
2. DSN <u>Delivery System Network</u> Provider Report	142 <u>Monitoring and Reporting Requirements 175</u>
3. Provider Capacity	144
4. —	
3. Cooperative Agreements with Publicly Funded Programs Report:	145 <u>177</u>
5. Cooperative Agreements with Community Social and Support Service and Long Term Care Report:	145 <u>178</u>
6. Hospital Network Adequacy	146 <u>178</u>
Exhibit H – Value Based Payment	148 <u>180</u>
1. VBP minimum threshold	148 <u>180</u>
2. Expanding 148 <u>VBP beyond primary care to other care delivery areas</u>	<u>180</u>
3. Patient-Centered Primary Care Home (PCPCH) VBP requirements	149 <u>181</u>
4. VBP Targets by Year	149 <u>181</u>
5. Contractor Data Reporting	149 <u>182</u>
Exhibit I – Grievance and Appeal System	151 <u>186</u>
1. Grievance and Appeal System 151 <u>– Requirements</u>	<u>186</u>
2. Grievances	152 <u>188</u>
3. Notice of Adverse Benefit Determination 153 <u>- Requirements</u>	<u>189</u>
4. Handling of Appeals	156 <u>192</u>
5. Contested Case Hearings	159 <u>196</u>
6. Continuation of Benefits:	159 <u>196</u>
7. Implementation of Reversed Appeal Resolution	161 <u>197</u>
8. Final Order on Contested Case Hearings	161 <u>198</u>
9. Record Keeping and Quality Improvement	161 <u>198</u>
10. OHA Review and Approval of Grievance and Appeal System, Policies and Procedures, and Member Notice Templates	<u>198</u>
Exhibit J - Health Information Technology	164 <u>202</u>
1. Health Information Technology Requirements	164 <u>202</u>
2. Health Information Technology (HIT) Roadmap	165 <u>203</u>
Exhibit K - <u>Social Determinants of Health and Equity</u>	<u>207</u>
1. <u>Community Advisory Council</u>	<u>207</u>
2. <u>Community Advisory Council Membership</u>	<u>207</u>
3. <u>Community Advisory Council Meetings</u>	<u>208</u>
4. <u>Duties of the CAC</u>	<u>208</u>
5. <u>Contractor’s Annual CAC Demographic Report</u>	<u>209</u>
6. <u>Community Health Assessment</u>	<u>210</u>
7. <u>Community Health Improvement Plan</u>	<u>212</u>
8. <u>Social Determinants of Health and Equity Spending Programs</u>	<u>215</u>
9. <u>Health-Related Services</u>	<u>220</u>
10. <u>Health Equity Plans</u>	<u>222</u>

<u>11. Traditional Health Workers</u>	<u>227</u>
Exhibit L — Solvency Plan and <u>Financial Reporting and Cost</u>	168 <u>Sustainable Rate of Growth</u> <u>231</u>
1. Overview of Solvency Plan and Financial Reporting	168 <u>231</u>
2. Solvency Plan and NAIC <u>Financial Reporting</u>	168 <u>231</u>
3. —	
3. <u>Supplemental Financial Reporting</u>	<u>232</u>
4. <u>Audited Financial Statements</u>	<u>232</u>
5. <u>Assumption of Risk/Private Market Reinsurance</u>	170 <u>233</u>
46. <u>Restricted Reserve and Financial Solvency Requirement</u>	170 <u>233</u>
7. <u>Sustainable Rate of Growth Requirement</u>	<u>234</u>
Exhibit M - Behavioral Health	172 <u>235</u>
1. Contractor Responsibilities	172
1. <u>Behavioral Health Requirements</u>	<u>235</u>
2. Covered <u>Financial Matters Relating to Behavioral Health</u> Services	173 <u>235</u>
3. Care Coordination and <u>Integration</u> 180 , <u>Transition, and Collaboration with Partners</u>	<u>236</u>
4. —	
4. <u>Policies and Procedures</u>	<u>236</u>
5. <u>Referrals, Prior Authorizations, and Approvals</u>	<u>237</u>
6. <u>Screening Members</u>	<u>237</u>
7. <u>Substance Use Disorders (“SUD”)</u>	<u>238</u>
8. <u>Assertive Community Treatment</u>	<u>239</u>
9. <u>Peer Delivered Services</u>	<u>240</u>
10. <u>Behavioral Health Crisis Management System</u>	<u>240</u>
11. <u>Care Coordination / Intensive Care Coordination</u>	<u>241</u>
12. <u>Community Mental Health Program</u>	<u>241</u>
13. <u>Oregon State Hospital</u>	<u>241</u>
14. <u>Emergency Department Utilization</u>	<u>242</u>
15. <u>Involuntary Psychiatric Care</u>	<u>242</u>
17. <u>Acute Inpatient Hospital Psychiatric Care</u>	<u>245</u>
18. <u>Women’s Health</u>	<u>246</u>
19. <u>Children and Youth Behavioral Health Services</u>	188 <u>246</u>
520. Reporting <u>193</u> <u>Requirements</u>	<u>250</u>
621. <u>Providers</u>	195 <u>251</u>
Exhibit N Social Determinants of Health and Health Equity	<u>196</u>
1. Community Advisory Council (CAC)	<u>196</u>
2. Community Health Assessment (CHA) and Community Health Improvement Plan (CHP)	<u>197</u>
3. Social Determinants of Health and Health Equity	<u>199</u>
4. Health-Related Services	<u>201</u>
5. Health Plan	<u>202</u>
Exhibit C-Attachment 1	207 <u>253</u>
<u>Appendix D</u>	<u>254</u>

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings. To request an alternate format, please call 503-378-3486 (voice) or 503-378-3523 (TTY) or send an email to dhs-oha.publicationrequest@state.or.us.

**OREGON HEALTH PLAN
HEALTH PLAN SERVICES CONTRACT
COORDINATED CARE ORGANIZATION**

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

XXXXX

XXXX

XXXX

hereinafter referred to as “**Contractor**.” OHA and Contractor are referred to as the “**Parties**.”

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

Health Systems Division (HSD)
500 Summer Street NE, E35
Salem, Oregon 97301
Contract Administrator: ~~Kathy Cereghino~~ or delegate
Phone: ~~503-947-5522~~
Fax: ~~503-945-5972~~
Email: ~~katherine.j.cereghino@state.or.us~~

1. Effective Date and Duration

~~A.~~ This Contract ~~is effective January~~ Effective Date is October 1, ~~2020~~2019, regardless of the date of signature. The Coverage Effective Date is January 1, 2019. This Contract, including 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 2020~~ CCO Payment Rates prior to the Coverage Effective Date, OHA ~~shall~~will pay Contractor at the ~~proposed~~ CCO Payment Rates and Contractor shall accept payment at the CCO Payment Rates, subject to adjustment upon ~~OHA’s receipt of~~ CMS approval or OHA modification of the ~~proposed~~ CCO Payment Rates. ~~Unless extended or terminated earlier in accordance~~ The Term of this Contract is for a period of five years from the Coverage Effective Date, unless terminated earlier as provided for in this Contract. Notwithstanding the foregoing, subject to ORS 414.652(1)(b), this Contract may be amended every 12 months after the Coverage Effective Date upon expiration of each Contract Year, with its terms, this the first Contract expires Year

~~expiring~~ on December 31, 2020. ~~In (the “Expiration Date”). Assuming event~~ Contractor ~~continues to satisfy~~ is in substantial compliance with the Readiness Review standards and is ~~otherwise not~~ in good standing ~~breach this Contract at the end of a Contract Year, OHA will offer Contractor an annual Renewal Contract, subject to (i) any amendments to the terms and conditions amending of this Contract, and (ii) the applicable provisions of ORS 414.652, OAR 410-141-3010, and OAR 410-141-3041, to renew this Contract for up to four additional annual, successive Contract Years.. In the event the Parties renew this Contract for all four additional Contract Years and is not earlier terminated in accordance with its terms-so that, the Term of this Contract will terminate~~expire on December 31, 2024. Contract expiration ~~or, termination, or the renewal of the Contract for an additional Contract Year~~ does not extinguish or prejudice OHA’s right to enforce this Contract with respect to any default by Contractor that has not been cured.

1.1. B. Contractor shall ~~notify OHA~~provide, in accordance with OAR 410-141-3041(2), OHA with notice of its intent not to renew this Contract for an additional Contract Year not less than 120- fourteen (14) days before the Expiration Date of its ~~after Contractor’s receipt of Administrative Notice of OHA’s proposed amendments to the Contract for the subsequent Contract Year. Contractor shall provide OHA with Legal Notice of such intent to not proceed with a Renewal Contract.~~to renew. .

~~H.~~ **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:—Value Based Payments~~

~~Exhibit I:—Grievance System~~

~~Exhibit J:—Health Information Technology~~

~~Exhibit L:—Solvency Plan and Financial Reporting~~

~~Exhibit M:—Behavioral Health~~

~~Exhibit N:—Social Determinants of Health and Equity~~

~~*Exhibit C Attachment 1 (CCO Specific Rates) is attached after Exhibit N.~~

~~B.~~ ~~Reporting forms and other reference documents are posted at <http://www.oregon.gov/OHA/healthplan/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.~~

1.2. 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

2. ~~IV.~~ Status of Contractor

2.1. ~~A.~~ Contractor is a (*Form of Legal Entity*) organized under the laws of Oregon.

2.2. ~~B.~~ Contractor designates:

xxx
xxx
xxx
Phone:
Fax:
Email:

as the ~~point of contact pursuant to Exhibit D, Section 24 of this~~ Contract Administrator.
Contractor shall ~~notify~~Notify OHA ~~in writing of any~~if the Contract Administrator or the
associated contact information changes ~~to the designated contact~~.

3. ~~V.~~ Enrollment Limits and Service Area

3.1. ~~A.~~ Contractor's maximum Enrollment limit by County is:

[enter limit] [enter county]
[enter limit] [enter county]
[enter limit] [enter county]

3.2. ~~B.~~ Contractor's maximum Enrollment limit is: (*Specific Plan Enrollment Limits*). 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 7, of this Contract; however, such additional Enrollment does not create a new maximum Enrollment limit.

4. ~~VI. Interpretation and~~ Entire Contract; Administration of Contract; Interpretation of Contract

4.1. Entire Contract.

This Contract consists of these General Terms, together with the following Exhibits and Exhibit attachments, and Reference Documents described in Section 4.1.1 below of these General Terms to the Contract:

- 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: Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy

Exhibit H: Value-Based Payments

Exhibit I: Grievance and Appeal System

Exhibit J: Health Information Technology

Exhibit K: Social Determinates of Health and Health Equity

Exhibit L: Solvency Plan and Financial Reporting

Exhibit M: Behavioral Health

*Exhibit C-Attachment 1 (CCO Payment Rates) and Exhibit B-Appendix 1 (Deliverables and Deliverable destination) are attached after Exhibit M.

4.1.1. Reference Documents are posted on the CCO Contract Forms Website located at:

<https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>

\ and other webpages expressly referenced in this Contract and are by this reference incorporated into the Contract. OHA may change the CCO Contract Forms Website URL after providing Administrative Notice of such change, with such change to be effective as of the date identified in such Administrative Notice.

All completed reporting forms must be submitted and, as may be applicable, attested to, by Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for reports as designated by the Signature Authorization Form available on the CCO Contract Forms Website.

4.1.2. This Contract is only comprised of documents that are expressly identified in these General Terms and Exhibits A through M.

4.2. 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.

4.3. Interpretation of Contract

In the provision of services required to be performed under this Contract, the ~~Contractor~~ Parties shall (1) comply with: (a) all applicable federal, and state ~~State~~ laws and regulations, and (b) the terms and conditions of this Contract, ~~reporting tools/ templates~~ and all amendments thereto; that are in effect on the Effective Date or come into effect during the ~~term~~ Term of this Contract; ~~and (2) require its Subcontractors to so comply. B.~~ In interpreting this Contract, the Parties shall construe its terms and conditions as much as possible to be complementary, giving preference to: the event Contractor subcontracts any of its obligations under this Contract, Contractor shall only do so in accordance with the terms and conditions set forth in Ex. B, Part 4 of this Contract and any other applicable provisions of this Contract.

4.3.1. To the extent provisions contained in more than one of the documents listed in Section 4.1 above of these General Terms apply in any given situation, the parties agree: (i) to read such provisions together whenever possible to avoid conflict, and (ii) to apply the following order of precedence only in the event of an irreconcilable conflict:

4.3.1.1. ~~1. This~~ These General Terms of the Contract (without exhibits, attachments, or ~~reference documents~~ Reference Documents) over any exhibits, attachments, or ~~reference documents~~ Reference Documents.

2. ~~The exhibit or attachment earlier in the Table of Contents over any exhibit or attachment later in the Table of Contents.~~

4.3.1.2. The Exhibits to these General Terms in the following order of precedence:

- i. Exhibit E: Required Federal Terms and Conditions 5
- ii. Exhibit A: Definitions
- iii. Exhibit B: Statement of Work
- iv. Exhibit D: Standard Terms and Conditions
- v. Exhibit C: Consideration
- vi. Exhibit L: Solvency Plan and Financial Reporting
- vii. Exhibit I: Grievance and Appeal System
- viii. Exhibit G: Reporting of Delivery System Network Providers, Cooperative Agreements and Hospital Adequacy
- ix. Exhibit M: Behavioral Health 13
- x. Exhibit K: Social Determinates of Health & Health Equity Reporting Requirements
- xi. Exhibit J: Health Information Technology
- xii. Exhibit H: Value-Based Payments
- xiii. Exhibit F: Insurance

4.3.1.3. ~~3.~~—This Contract (with exhibits and attachments) over any ~~reference documents~~ Reference Documents.

~~4.—Reference documents in alphabetical order.~~

4.3.1.4. When determining the order of precedence of any Reference Document with respect to an Exhibit, the Exhibit in which such Reference Document is referenced shall take precedence over such Reference Document. When determining the order of precedence of a Reference Document with respect to an Exhibit other than the Exhibit in which the Reference Document is referenced, the Reference Document will be given the same order of precedence in which the Reference Document is first identified. For purposes of illustration only, if the Parties cannot reconcile an apparent conflict between Exhibit B-Part 1 and the CHIP Progress Report Guidance Template, which is first referenced in Exhibit N, the apparent conflicting provision in Exhibit B-Part 1, shall take precedence over the CHIP Progress Report Guidance Template. In addition, and again for illustrative purposes only, if the Parties cannot reconcile an apparent conflict between Exhibit N and the CHIP Progress Report Guidance Template, which is the Exhibit in which such Guidance Template is first referenced, the provisions expressly set forth in Exhibit N shall take precedence.

4.3.2. ~~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,~~ list set forth below in this Section 4.3.2 of these General Terms in the order of precedence ~~as listed~~. The sources shall be considered in the form they took at the time the event occurred, or at the time of the obligation or action that gave rise to the need for interpretation. But if a different time period or order of precedence is otherwise identified in a provision of this Contract, then such identified order of precedence shall govern.

- 4.3.2.1. ~~1.~~ The Oregon State Medicaid Plan and any ~~Grant Award Letters~~grant award letters, waivers or other directives or permissions approved by CMS for operation of the Oregon Health Plan (~~OHP~~).
- 4.3.2.2. ~~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.
- 4.3.2.3. ~~3.~~ The Oregon Revised Statutes (~~ORS~~) or other enacted Oregon Laws concerning the OHP.
- 4.3.2.4. ~~4.~~ The Oregon Administrative Rules (~~OAR~~) promulgated by OHA and other OARs applicable to Medical Assistance Programs and health services prior to the Effective Date of this Contract or subsequent amendments to the Contract, to implement the OHP.
- 4.3.2.5. ~~5.~~ The OARs promulgated after the Effective Date of this Contract or subsequent amendments to the Contract, if OHA includes with the rulemaking a statement that the rule either (a) is expected to have de minimis impact on CCO finances and operations; or (b) is required by changes in state~~State~~ law, changes in federal law or written guidance, or changes ~~initiated by CMS~~ in OHA's OHP waivers or state~~State~~ plan.
- ~~6. — Other applicable Oregon statutes and OARs concerning the Medical Assistance Program and health services.~~
- 4.3.3. ~~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~~promptly Notify OHA.
- 4.3.4. 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, Contractor shall enter into ~~an amendment required by OHA~~any and all amendments to ~~amend~~ this Contract that are necessary to conform to those laws or regulations.

5. ~~VII.~~ Contractor Data and Certification

~~A.~~ Contractor Information. Contractor shall provide information set forth below. This information is requested pursuant to ORS 305.385.

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~~delivering, via Administrative Notice, a certificate of insurance as required ~~in Exhibit~~under Ex. F, ~~Section~~Sec. 9.

Please print or type the following information

NAME (exactly as filed with the IRS):

Street Address: _____

City, state, zip code: _____

Telephone: () _____ Facsimile Number: () _____

E-mail address: _____

Social security number or FEIN **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 Contract.

Professional Liability Insurance Company _____

Policy # _____ Expiration Date: _____

Commercial General Liability Insurance Company _____

Policy # _____ Expiration Date: _____

Auto Insurance Company _____

Policy # _____ Expiration Date: _____

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: _____

Policy # _____ Expiration Date: _____

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

Form of Legal Entity: *(Check one box):*

Professional Corporation

Nonprofit Corporation

Insurance Corporation Limited Liability Company

 Business Corporation

5.1. B-Certification and Acknowledgement. Without limiting the ~~generality of the foregoing applicability of any other State or federal law~~, by signature on this Contract, the Contractor hereby certifies and acknowledges that:

5.1.1. ~~1-~~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. 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.

5.1.2. ~~2-~~Contractor certifies that Contractor has a written policy and practice that meets the requirements, described in ORS 279A.112, of preventing sexual harassment, sexual assault, and discrimination against employees who are members of a protected class. Contractor agrees, as a material term of the Contract, to maintain such a policy and practice in force during the entire Contract term.

5.1.3. ~~3-~~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~~ after due inquiry for a period of no fewer than six (6) calendar years preceding the Effective Date, has complied with all applicable 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 local taxes administered by the Department of Revenue under ORS 305.620;

5.1.4. ~~4-~~Contractor acknowledges that the Oregon Department of Administrative Services will report this Contract to the Oregon Department of Revenue (DOR). The DOR may take any and all actions permitted by law relative to the collection of taxes due to the State of Oregon or a political subdivision, including (i) garnishing the Contractor's compensation under this Contract or (ii) exercising a right of setoff against Contractor's compensation under this Contract for any amounts that may be due and unpaid to the State of Oregon or its political subdivisions for which the DOR collects debts;

5.1.5. ~~5-~~The information shown in Part VII, Section A, “Contractor Data and Certification” above is Contractor's true, accurate and correct information;

5.1.6. ~~6-~~To the best of the undersigned's knowledge after diligent inquiry, 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;

5.1.7. ~~7-~~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.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx>;

5.1.8. ~~8-~~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;

5.1.9. ~~9.~~ 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.

5.1.10. ~~10.~~ Contractor is an independent contractor as defined in ORS 670.600.

5.2. ~~€.~~ By Contractor’s signature on this Contract, Contractor hereby certifies that the FEIN provided [in Section 5.1 above of these General Terms](#) is true and accurate. If this information changes, Contractor ~~is required to~~shall provide OHA with the new FEIN within ten (10) days of the date of change.

5.3. VIII. Signatures

BY SIGNATURES BELOW, THE PARTIES AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THIS CONTRACT.

CONTRACTOR

By _____

Authorized _____ Date _____

Printed Name: _____

Title _____

OHA—Health Systems Division

By _____

~~Patrick Allen, Oregon Health Authority Director~~ _____ Date _____

Printed Name _____

Approved as to Legal Sufficiency:

~~Electronic approval by Theodore C. Falk, Senior Assistant Attorney General, Health and Human Services Section, on XXXXXX, 2019; email in Contract file.~~

Reviewed by OHA Contract Administration:

By _____

~~Kathy Cereghino, Contract Administrator~~ _____ ~~Date~~

CONTRACTOR

OHA – HEALTH SYSTEMS DIVISION

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Approved as to Legal Sufficiency:

Electronic approval by Theodore C. Falk, Senior Assistant Attorney General, Health and Human Services Section, on XXXXXX, 2019; email in Contract file.

Reviewed by OHA Contract Administration:

By: _____

Printed Name: _____

Title: _____

Date: _____

Exhibit A - Definitions

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

1. Express definitions in ~~this~~ Exhibit A,
2. Express definitions elsewhere in this Contract,
3. Definitions in the OARs cited ~~below~~, in ~~the order cited~~, Exhibit A, and

~~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~~

4. Definitions in OARs not specifically cited in Exhibit A.

[See ~~RFA~~Request For Application Appendix A]

[Remainder of page intentionally left blank]

Exhibit B – Statement of Work - Part 1—

Governance and Organizational Relationships

1. Governing Board and Governance Structure

- a.** Contractor shall establish, maintain, and operate with a Governance Structure that complies with the requirements of ORS 414.625~~(1)(o)~~ and OAR 410-141-3025.
- b.** Contractor shall annually provide ~~annually to~~ OHA ~~the with a then-current~~ organizational chart or listing presenting the identities of and interrelationships between the parent, the Contractor, Affiliated insurers—and, Affiliated reporting entities, and other Affiliates. The ~~organization~~organizational chart must show all lines of ownership or Control up to Contractor's ultimate ~~controlling~~Controlling person, all subsidiaries of Contractor, and all Affiliates of Contractor that are relevant to ~~this~~the Application that Contractor submitted in response to RFA OHA-4690-19 – CCO 2.0. ~~When~~

 - (1)** In the event there are interrelationships ~~are aof~~ 50/50% ownership, footnote any voting rights preferences that one of the entities or person may have.
 - (2)** For each entity, identify the :

 - (a)** corporate structure, two-character state abbreviation of the state of domicile, and
 - (b)** Federal Employer's Identification Number, and NAIC code for insurers.
 - (3)** A completed Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required ~~by~~under this ~~question~~Para. b., Sec. 1, of this Ex. B, Part 1.
 - (4)** If ~~any~~ subsidiary or other Affiliate performs business functions for Contractor, describe the functions in general terms.
- c.** Contractor shall annually provide ~~annually to~~ OHA with a description of Contractor's Governing Board's key committees, including each committee's composition, reporting relationships and responsibilities, oversight responsibility, ~~monitoring~~Monitoring activities and other activities performed.
- d.** Contractor must submit its then-current organizational chart and key committee descriptions to OHA via Administrative Notice by no later than January 30 of Contract Years two through five.

2. Clinical Advisory Panel

Contractor shall establish an approach within its Governance Structure to assure best clinical practices. This approach is subject to OHA approval; and may include a Clinical Advisory Panel. If Contractor convenes a Clinical Advisory Panel, it ~~will~~must include representation from Behavioral Health, physical health systems, and ~~oral health~~Oral Health.

3. Innovator Agent and Learning Collaborative

- a.** OHA will assign an Innovator Agent to ~~the~~ Contractor. The Innovator Agent's ~~roles are to act is~~ responsible for: (i) serving as a single point of contact between the Contractor and OHA on matters regarding innovation, ~~to facilitate~~(ii) facilitating the exchange of information, ~~to work~~(iii) working with the Contractor and its ~~Community Advisory Council~~CAC, and ~~to work~~(iv) working

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~~once per month.

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

1. Covered Services

Contractor shall provide and pay for Covered Services ~~listed as required~~ in this Exhibit B, ~~in exchange for the CCO Payment described in Exhibit C-Part 2 and as otherwise provided in this Contract.~~

- 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~~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~~set forth 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~~including without limitation, disabilities or ~~Coco-morbid~~ Condition/conditions, Contractor shall determine whether the Member has a funded ~~Condition/Treatment Pair~~condition/treatment pair that would entitle the Member to treatment under OAR 410-141-0480.
- g. Prior to performing any transplant surgery Contractor shall ~~notify~~provide OHA's Transplant Coordinator with Administrative Notice 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. Except as permitted under Section 1903(i) of the Social Security Act, 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~~Fee-for-service~~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 a disease, condition or disorder that results in health impairments or disability;
 - (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~~create a written UM Handbook that sets forth Contractor's utilization management policies, procedures and criteria for Covered Services. ~~These utilization management procedures~~The UM Handbook must ~~be consistent~~comply with ~~appropriate~~the utilization control requirements ~~of~~set forth in 42 CFR Part 456, ~~which includes~~including, without limitation the minimum health record requirements set forth in 42 CFR §456.111 and 42 CFR §456.211 for Hospitals and mental ~~hospitals~~Hospitals as ~~listed below~~follows:
- (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;
 - (4) The plan of care (as required under 45 CFR §456.180 for mental ~~hospitals~~Hospitals or 45 CFR §456.80 for ~~hospitals~~Hospitals);
 - (5) Initial and subsequent continued stay review dates (described under 42 CFR §456.233 and 456.234 for mental ~~hospitals~~Hospitals and 42 CFR §456.128 and 456.133 for ~~hospitals~~Hospitals);
 - (6) Reasons and plan for continued stay if ~~applicable~~the attending physician determines continued stay is necessary;
 - (7) Other supporting material the committee believes appropriate to include; and
 - (8) For non-mental ~~hospitals~~Hospitals only:
 - (a) Date of operating room reservation; and
 - (b) Justification of emergency admission if applicable.
- d. Contractor's utilization management policies ~~may, procedures, and criteria shall~~ not be structured so as to provide incentives for its Provider Network, employees, or other ~~utilization reviewers~~Utilization Reviewers to inappropriately deny, limit, or discontinue Medically Appropriate services to any Member.
- e. Contractor shall ensure that medical necessity determination standards and any other quantitative or non-quantitative treatment limitations, applied to ~~covered services~~Covered Services are no

more restrictive than those applied to ~~fee-for-service covered services, as described in~~Service Covered Services, as required under 42 CFR §438.210(a)(5)(i).

- f.** Contractor shall provide OHA with its UM Handbook upon request, which shall be made to Contractor's Contract Administrator via Administrative Notice. Contractor shall provide OHA with its UM Handbook in the manner and to the location identified by OHA in its request. OHA will have the right to review and approve Contractor's UM Handbook. OHA will provide, to Contractor's Contract Administrator via Administrative Notice, written approval or disapproval of the UM Handbook within thirty (30) days of receipt. In the event OHA disapproves of Contractor's UM Handbook, Contractor shall, in order to remedy the deficiencies in Contractor's UM Handbook, follow the process set forth in Ex. D, Sec. 5 of this Contract.
- g.** ~~f.~~ Contractor's must also implement a DUR Program as required under 42 CFR §438.2(s)(4)-(5) and 42 CFR Part 456, Subpart K. In connection with such program, Contractor must have a DUR Program Handbook that sets forth Contractor's written policies and procedures relating to drug utilization review programs, including that complies with Section 1927 of the Social Security Act and 42 CFR, part 456, subpart (K) and, without limiting the foregoing, must address coverage criteria, are subject to approval by OHA and must be submitted for review and approval by OHA. Contractor's drug utilization review programs shall which must be developed in accordance with evidence-based Evidence-Based practices based upon peer-reviewed, clinical literature, and evidence-based Evidence-Based practice guidelines from national and/or international professional organizations and in accordance with. As required under 42 CFR 438.3§438.2(s)(4)-(5). OHA will notify Contractor if it determines that Contractor's Contractor shall annually provide OHA, via Administrative Notice, with its DUR Program Handbook, which will be subject to review and approval by OHA. OHA will provide Contractor's Contract Administrator with Administrative Notice of its approval or disapproval of Contractor's DUR Program Handbook within thirty (30) days of receipt. It is Contractor's responsibility to ensure its drug utilization review program is not compliantcomplies with applicable state or federal lawsall Applicable Laws. IfIn the event OHA determines that Contractor's drug utilization review policies areDUR Program Handbook does not compliantcomply with applicable state or federal lawsthe terms and conditions of this Contract, Contractor shall revise its policies to be compliant, in order to remedy the deficiencies in such Handbook, follow the process set forth in Ex. D, Sec. 5 of this Contract.

3. Authorization or Denial of Covered Services

- a.** Contractor shall ~~establish and adhere to~~draft a Service Authorization Handbook that sets forth Contractor's written policies and procedures that comply with 42 CFR §438.210 and OAR 410-141-3225 to ensure consistent application of review criteria for authorization decisions. Contractor shall ensure processes allow for consultation with a requesting Provider for medical services when necessary and that processes are in place for both the initial and continuing Service Authorization Requests. Contractor shall require its Participating Providers and Subcontractors to adhere to establishedSuch policies for Service Authorization Requests. Theand procedures must requireinclude, without limitation: (i) those procedures that must be followed in order to obtain initial and continuing Service Authorizations, and (ii) the requirement 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, mentalbehavioral, or oral healthOral Health condition or disease in accordance with 42 CFR §438.210. b. Contractor ~~may~~must require ~~Membersits Participating Providers~~ and Subcontractors to ~~obtain authorization~~

~~for Covered Services from Contractor, except to the extent Prior~~adhere to the policies and procedures set forth in the Service Authorization is prohibited by OHP rules or elsewhere in this Contract Handbook.

- ~~e. Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to behavioral health Assessment and Evaluation services. Members may refer themselves to behavioral health services available from the Provider Network.~~
- ~~d. Contractor shall permit Members to refer themselves to a Traditional Health Worker for services within the scope of practice defined in Oregon Administrative Rule.~~
- ~~e. Contractor shall ensure the provision of sexual abuse exams without Prior Authorization.~~
- b. Without limiting Para. a. above of this Sec. 3, Ex. B, Part 2, Contractor's Service Authorization Request policies and procedures must comply with all of the following and provide that:
- (1) ~~f.~~ Contractor shall ~~have in effect~~implement mechanisms to ensure consistent application of review criteria for ~~authorization~~Service Authorization and Prior Authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.;
- ~~g. Contractors~~
- (2) Any and all decisions 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, Oral Health condition, or disease;
- (3) Contractor can require Members and Subcontractors to obtain Prior Authorization for Covered Services from Contractor provided that: (i) such Prior Authorization does not violate any Applicable law, and (ii) in accordance with 41 CFR §438.210(4) and 42 CFR §441.20: (a) the services supporting individuals with ongoing or chronic conditions, or those who require Long Term Services and Supports are authorized in a manner that reflects the Member's ongoing need for such services, (b) family planning services are provided in a manner that protects and enables a Member's freedom to choose a method of family planning, (c) the services furnished are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. ;
- (4) Members shall not be required to obtain Prior Approval or a Referral from a Primary Care Physician in order to gain access to Behavioral Health assessment and evaluation services. Members may Refer themselves to Behavioral Health services available from the Provider Network;
- (5) Members shall have the right to refer themselves to a Traditional Health Worker for services within the scope of practice defined in Oregon Administrative Rules;
- (6) Members shall have the right to have a sexual abuse exam without Prior Authorization.
- (7) Contractor must permit ~~out-of-network IHCPs to refer a CCO-enrolled Indian to a network provider for covered services as required by~~its Indian Members to obtain Covered Services from Non-Participating Providers, and be referred to a Participating Provider for Covered Services by, IHCPs in accordance with 42 CFR §438.14(b)(4) and (6).;

- (8) ~~h.~~ In accordance with 42 CFR §438.210(d)(1), Contractor shall provide notice to, in response to all standard Service Authorization Requests, Contractor shall provide notice to the requesting ~~provider~~Provider as expeditiously as the Member's health or ~~mental health~~Behavioral Health condition requires, not to exceed ~~14~~fourteen (14) calendar days following receipt of the request for service, with a possible extension of fourteen (14) additional calendar days if the Member or Provider requests extension, or if the Contractor justifies a need for additional information and ~~how can demonstrate that~~ the extension is in the Member's interest. ~~If~~In accordance with 42 CFR §438.210(d)(1) in the event Contractor ~~extends~~cannot meet the 14 (fourteen) day time frame, Contractor ~~shall provide~~may extend its time for decision by an additional fourteen (14) days subject to (i) providing the effected Member and the Member's Provider with a written notice of the reason for the decision to extend the timeframe it requires additional time, (ii) how such additional time is in the Member's best interest, and (iii) and inform the Member of the right to file a Grievance if he or she in accordance with Ex. I of this Contract if such Member disagrees with that decision. When such request. In addition, when Contractor fails to provide notice of a decision is not reached regarding a Service Authorization Request within the timeframes specified above in this Sub. Para. (8) of this Para. b, Ex. B, Part 2, or if an CCO Contractor denies a service authorization request Service Authorization Request, or decides to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall issue a notice of adverse benefit determination to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance System. Adverse Benefit Determination in accordance with Exhibit I of this Contract. Contractor must also provide the information it provides to Members and Providers under this Sub. Para. (8), Sec. 3, Ex. B, Part 2 to OHA or its designee upon request;
- (9) ~~i.~~ 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, and provide Notice notice, as expeditiously as the member Member's health or mental health condition requires and no later than 72 hours after receipt of the request for service. Contractor may extend the 72 hour time period by up to 14 days if the Member requests an extension, or if Contractor justifies a need for additional information and how demonstrates that the extension is in the Member's interest. If Contractor denies an expedited service authorization request under this Para. b of this Sec. 3, Ex. B, Part 2, or decides to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall issue a notice of an Adverse Benefit Determination to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance and Appeal System;
- (10) ~~j.~~ For all covered outpatient drug authorization decisions, Contractor must provide a response as described in section 1927(d)(5)(A) of the Act and 42 USC 1396r-8(d)(5)(A) and OAR 410-141-3225;
- (11) ~~k.~~ Contractor may shall not have the right to 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;

- (12) ~~l.~~ Contractor shall ensure that Dental Services ~~which~~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.;
- (13) ~~m.~~ ~~Except as provided in Subsection m. of this section,~~ Contractor ~~may~~shall not ~~have the right, except as permitted under Sub. Para. (12) of this Para. b, Ex. B, Part 2 of this Contract, to~~ 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~~undertaking any of the activities set forth below in this Sub. Para. (13), Para. b, Ex. B, Part 2 of this Contract, on behalf of ~~a Member,~~Members who ~~is a patient~~are patients of ~~the such~~ Health Care ~~Professional,~~for the following Professionals:
- (a) ~~(1) For the Member~~Advising or otherwise advocating for a 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;
- (b) ~~(2) Any~~Providing any and all information ~~the~~a Member needs in order to decide among relevant treatment options;
- (c) ~~(3) The~~Advising a Member of the risks, benefits, and consequences of treatment or non-treatment; and
- (d) ~~(4) The~~Advising and advocating for a Member's right to participate in decisions regarding ~~his or her~~the Member's own health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- (14) Contractor shall provide written notification to the requesting Provider when Contractor denies a request for authorization of a Covered Service or when Contractor approves a Service Authorization Request but such approval is for an amount, duration, or scope that is less than requested; and
- (15) Contractor shall provide written notification to the affected Member when Contractor denies a Service Authorization Request, or approves a Service Authorization Request but such approval is for an amount, duration or scope that is less than requested. Such written notification must be made in accordance the requirements of Exhibit I.
- c. ~~n.~~ ~~Notwithstanding the requirements of Subsection l. of this section~~In accordance with 42 CFR §438.102, Contractor is not required, ~~subject to compliance with this Para. c, Sec.3, Ex. B, Part 2 of this Contract,~~ 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~~must include in its Service Authorization Handbook its policy for such election and ~~furnish information about the services Contractor does not cover.~~include such policy in its Member Handbook in accordance with. 42 CFR §438.10(g)(2)(ii)(A)-(B).
- (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~~must have first provided, in accordance with OAR

42 CFR §438.102(b), OHA with notice of such election in its Application to the RFA and also provide OHA with Administrative Notice of its written policy as follows:

- (a) ~~To the OHA Contract Administration Unit annually~~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; and~~Upon any material changes (which may not be implemented by Contractor until approved in accordance with this Sec. 3, Ex. B, Part 2); and
- (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.~~Any time, upon OHA request.

(2) Within thirty (30) days of receipt of Contractor's its policy under Sub. Para (1) of this Para. c, Sec. 3, Ex. B, Part 2 of this Contract, OHA will provide Contractor's Contract Administrator with Administrative Notice of its approval or disapproval of such policy. In the event OHA determines Contractor's policy under Sub. Para (1) of this Para. c, Sec. 3, Ex. B, Part 2 of this Contract does not comply with 42 CFR §438.10 or any other Applicable Law, Contractor shall follow the process set forth in S. 5, Ex. D.

(3) ~~(2) Subject to OHA prior approval,~~ Contractor shall furnish ~~such information~~its policy of non-coverage, as approved in writing by OHA to:

- (a) Potential Members before and during Enrollment; and
- (b) Members thirty (30) days prior to the effective date of the policy with respect to any particular service (which is the date on which OHA provides written approval of such policy).

~~o. 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.~~

~~p. 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~~ Component: Crisis, Urgent and Emergency Services

Without limiting ~~the generality of~~ Contractor's obligation to provide integrated care and coordination for Covered Services, the following responsibilities are required ~~by law~~pursuant to OAR 410-141-3140, 42 CFR §42.114 and other Applicable Laws, and must be implemented in conjunction with ~~its~~Contractor's 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~~Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- (2) Contractor shall provide an after-hours call-in system adequate to ~~Triagetriage~~Urgent Care and Emergency Service calls, consistent with OAR 410-141-3140.

- (3) ~~As provided for in OAR 410-141-3140 and 42 CFR §438.114,~~ Contractor shall ~~cover and not deny, but must~~ pay for a claim for Emergency Services, regardless of whether the ~~provider~~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 Member is discharged, consistent with the requirements of 42 CFR §438.114.
- (8) Contractor shall cover Post Stabilization Services administered to maintain, improve, or resolve the Member's stabilized condition without preauthorization, and regardless of whether the Member 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~~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 any failure of an~~ emergency room ~~provider, hospital~~Provider, Hospital, or fiscal agent ~~not notifying the to~~ notify a Member's ~~primary care provider~~Primary Care Provider of the Member's screening and treatment within ten (10) days of presentation for Emergency Services, as specified in 42 CFR § 438.114.
- (11) Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructs the ~~member~~Member to seek ~~emergency services~~Emergency Services. 42 CFR § 438.114.
- (12) In accordance with OAR 410-141-3460 and 410-120-0000(91) Contractor shall pay for emergency Ambulance transportation for Members, including Ambulance services dispatched through 911, ~~in accordance with the~~ when a Member's medical condition

~~requires~~ Emergency Services ~~prudent layperson standard described in Exhibit A, definitions for “Emergency Services” and “Emergency Medical Condition.”~~

5. b. Covered Service Component: Non-Emergent Medical Transportation (NEMT)

- a.** Contractor is responsible for ensuring ~~members~~Members have access to safe, timely, appropriate Non-Emergent Medical Transportation services in accordance with OAR 410-141-3435 through 410-141-3485.
- b.** In the event Contractor Subcontracts any of its NEMT services to a third-party, Contractor shall comply with all of the applicable provisions of Subcontracting as set forth in Ex. B, Part 4 and any and all credentialing requirements set forth in this Contract.
- c.** Contractor shall develop and implement systems supported by written policies and procedures ~~to that~~ describe the process for receiving ~~member~~Member requests, approving NEMT services, and scheduling, assigning, and dispatching ~~providers.~~
- (1)** ~~As part of the approval~~Providers. Contractor shall provide its NEMT policies and procedures to OHA, via Administrative Notice, for review and approval for compliance with the criteria set forth in this Ex. B, Part 2 and other applicable provisions of this Contract as follows: (i) on November 1, 2019; (ii) upon any material change to such policies and procedures (such changes may not be implemented until approved in writing by OHA); and (iii) within five business days of request, as made by OHA from time to time. In the event OHA does not approve Contractor’s NEMT policies and procedures for failure to comply with the criteria set forth in this Ex. B, Part 2, Contractor and any other applicable provisions of this Contract, Contractor shall follow the process,~~the~~Contractor shall: set forth in Sec. 5, Ex. D of this Contract.
- d.** All such policies and procedures must be provided to all Members and address all of the items set forth under this Ex. B, Part 2, Sec. 5, Para. a, as follows:
- (1)** Describe Member and passenger rights and responsibilities, including the right to file complaints about the safety, quality, or appropriateness (or any combination, or all, of the foregoing) of services provided or a Grievance.
- (a)** If filing a Grievance, Contractor shall direct Members to comply with its Grievance and Appeal System in accordance with Ex. I to this Contract.
- (b)** If filing a complaint about the safety, quality, or appropriateness of services, Contractor must have processes and procedures that meet all the accessibility and accommodation standards set forth in Sec. 2 Exhibit B, Part 4. Contractor must also have a policies and procedures that allow Members to make service quality complaints directly to either or both Contractor and any Subcontractor providing the NEMT Services. Contractor shall not preclude Members from making complaints that have been made previously or from filing or submitting the same complaint to both Contractor and the applicable Subcontractor.
- (c)** Contractor must have a process for documenting, responding to, addressing or otherwise resolving all service quality complaints regardless of whether such complaints involve services provided by Contractor itself or a Subcontractor.

- ;
- (2) Approval of NEMT Services which requires Contractor to:
- (d) ~~(a)~~ Verify the ~~member~~Member's eligibility for NEMT services;
 - (e) ~~(b)~~ Determine the appropriate mode of ~~transportation~~Transportation for the ~~member~~Member;
 - (f) ~~(c)~~ Determine the appropriate level of service for the ~~member~~Member;
 - (g) ~~(d)~~ Approve or deny the request in accordance with OAR 410-141-3225 through 410-141-3255, 410-141-3435(6), and OAR 410-141-3465(2); and
 - (h) ~~(e)~~ Enter the appropriate information into the Contractor's system.
- (3) ~~(2) Verifying Eligibility~~Verification of eligibility for NEMT Services
- ~~The Contractor shall screen~~by screening and confirming all requests for NEMT ~~services-~~to confirm each of the following items Services as follows:
- (a) That the person for whom the ~~transportation~~Transportation is being requested is ~~an OHP enrollee and enrolled in the~~a Member Enrolled with Contractor's CCO;
 - (b) That the service for which NEMT ~~service~~Service is requested is ~~an OHP covered service or for flex services as determined by a~~ Covered Service or flex service or, in the case of FBDE Members, that such Members require NEMT to travel to a Medicaid or Medicare covered appointment within Contractor's Service Area or outside the Service Area if NEMT Services are not available within Contractor's Service Area and for which Contractor is responsible for cost sharing, including the ~~CCO~~NEMT Services;
 - (c) That the ~~enrollee~~Member is eligible for services;
 - (d) For all FBDE Members, verify eligibility for services with such Members' MA or DSPN Plans, or directly with such Members' Medicare Provider; and
 - (e) ~~(d)~~ That the ~~transportation~~Transportation is a ~~covered~~Covered NEMT ~~service~~Service.
- (4) Service Modifications to address safety of passengers and drivers in accordance with OAR 410-141-3470, which must include modifications when a Member:
- (a) Has a health condition that presents a direct threat to the driver or others in the vehicle;
 - (b) Threatens harms to the driver or others in the vehicle or engages in behavior or creates circumstances that puts the driver or others in the vehicle at risk of harm;
 - (c) Is required, in Contractor's judgment, in order to ensure Providers will provide the Covered Services to a Member; and
 - (d) Frequently cancels or does not show up for the scheduled NEMT Services on the date such Service is to be provided
- (5) ~~(3)~~ Determining the Appropriate Mode of Transportation

~~Contractor shall determine what mode of transportation is appropriate to meet the needs of the member.~~

~~In order to determine the appropriate mode of transportation, the Contractor shall~~Member by determining or assessing whether the Member:

- ~~(a) Determine whether the member is~~Is ambulatory and the ~~member~~Member's current level of mobility and functional independence;
- ~~(b) Determine whether the member will~~Will be accompanied by an attendant, including those permitted under OAR 410-141-3450, and, if so, whether the ~~member~~Member requires assistance and whether the attendant meets the requirements for an attendant;
- ~~(c) Determine whether a member is~~Is under the age of eighteen (18) and will be accompanied by an adult; ~~and~~
- ~~(d) Assess~~Has any special conditions or needs ~~of the member,~~ including physical or ~~behavioral health~~Behavioral Health disabilities and modify, as may be required, the NEMT Services in accordance with OAR 410-141-3465. Based on approval of previous NEMT ~~services~~Services, ~~the~~ Contractor shall display ~~members~~Members' permanent and temporary special needs, appropriate mode of ~~transportation~~Transportation, and any other information necessary to ensure that appropriate ~~transportation~~Transportation is approved and provided; ~~and~~
- ~~(e) Requires Secured Transport in accordance with OAR 410-141-3455.~~

~~(6) (4) Timely~~Ensuring timely access for NEMT ~~services~~(a) Services which must include
Contractor ~~shall arrange~~;

- ~~(a) Arranging for NEMT services~~Services to be available in a timely manner to ensure ~~members~~Members arrive at their destination with sufficient time to check in and prepare for an appointment. ~~Access~~Timely access to NEMT ~~services~~Services also applies to the timely pick up of ~~members~~Members at the end of their ~~appointment~~appointments to provide the return trip without excessive delay; ~~and~~
- ~~(b) Contractor shall have policies and procedures that describe~~Implementing contingency plans for unexpected peak ~~transportation~~Transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service; ~~and~~
- ~~(c) When~~Prior to entering into a contract with an NEMT ~~provider, Contractor shall~~conductProvider, conducting a readiness review of ~~subcontracted~~ NEMT brokerages or other entities providing NEMT ~~services~~Services in line with the ~~subcontractor~~Subcontractor readiness review requirements. Contractor shall ensure that NEMT drivers undergo background checks and are subject to the Participating Provider credentialing requirements of OAR 410-141-3120 prior to providing services. Contractor shall ensure that NEMT ~~services~~Services are only provided using vehicles that meet all of the requirements set forth in OAR 410-141-3440 and are operated by drivers who ~~are screened and credentialed, and that all drivers maintain proof of insurance~~meet all of the requirements, and have

undergone all of the required screening, credentialed, background checks required, under OAR 410-141-3440.

~~(7)~~ ~~(5)~~ Requesting NEMT Services, which must permit Members or their representatives ~~shall be allowed~~ to make requests for NEMT ~~services~~Services on behalf of ~~members~~Members. For purposes of this Para. b, Sub. Para (7), Sec. 4, Ex. B, Part 2, Representatives include the ~~member~~Member's ~~community health worker~~Community Health Worker, foster parent, adoptive parent, or other ~~provider~~Provider delegated with this authority.

~~(8)~~ ~~(6)~~ Scheduling, ~~Assigning~~assigning, and ~~Dispatching Trips~~

~~(a)~~ ~~The~~dispatching trips which must include Contractor ~~shall ensure that covered~~;

~~(a)~~ Providing Covered NEMT ~~services are available~~Services twenty-four (24) hours a day, three hundred and sixty-five (365) days a year; and, in accordance with OAR 410-141-3435, and which permit Members to schedule same day NEMT Services and also at least twenty-four (24) hours in advance;

~~(b)~~ AfterScheduling and assigning the requested Transportation to an appropriate NEMT Provider after approving a NEMT ~~service~~Service to be provided by a NEMT ~~provider~~Provider (i.e., not fixed route), ~~the Contractor shall schedule and assign the trip to an appropriate NEMT provider;~~

~~(c)~~ ~~The Contractor shall approve~~Approving and ~~schedules~~scheduling or ~~deny~~denying a request for NEMT (including all legs of the trip) Services within twenty-four (24) hours of receiving the request. This timeframe shall be reduced as necessary to ensure the ~~member~~Member arrives in time for ~~his/hersuch~~Member's appointment. ~~Failure to comply with this requirement may result in liquidated damages as described in the Contract and Oregon Administrative Rule.; and~~

~~(d)~~ ~~The Contractor shall ensure that~~Ensuring trips are dispatched appropriately and meet the requirements of this Section and the needs of the Member. The dispatcher shall, at minimum, provide updated information to drivers, ~~monitor~~Monitor drivers' locations, and resolve pick-up and delivery issues.

~~(9)~~ ~~(7)~~ Accommodating Scheduling Changes

~~(a)~~ ~~The, which must include~~ Contractor ~~shall accommodate~~accommodating unforeseen schedule changes ~~and shall timely assign, including the timely reassignment of the affected~~ trip to another NEMT ~~provider~~Provider if necessary. ~~The~~ Contractor shall ensure that neither NEMT ~~providers~~Providers nor drivers change the assigned pick-up time without prior, documented permission from ~~the~~ Contractor.

~~(10)~~ ~~(8)~~ Notifying Members

If, which must include, when possible, ~~the~~ Contractor ~~shall inform the member~~informing Members of the ~~transportation~~Transportation arrangements during the phone call requesting the NEMT ~~service~~Service. Otherwise, ~~the~~ Contractor ~~shall~~must obtain the ~~member~~Member's preferred method (e.g., phone call, email, fax) and time of contact, and ~~the~~ Contractor ~~shall~~must notify ~~the member~~Members of the ~~transportation~~Transportation

arrangements as soon as the arrangements are in place and prior to the date of the NEMT ~~service~~Service.

(11) Responsibility of determining whether ~~transportation~~Transportation arrangements have been made shall not be delegated to ~~the member~~any Member. Information about ~~transportation~~Transportation arrangements ~~shall~~must include but not be limited to the name and telephone number of the NEMT ~~provider~~Provider, the scheduled time and address of pick-up, and the name and address of the ~~provider~~Provider to whom the ~~member~~Member seeks transport.

(12) ~~(9)~~-Adverse Weather Plan

~~The Contractor shall have policies and procedures for transporting members, which must provide for the transportation of Members~~ who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. “Adverse weather conditions” includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall, or icy roads. The policies and procedures shall include, at a minimum, staff training, methods of notification, and ~~member~~Member education.

(13) ~~(10)~~-Contingency and Back-Up Plans

~~The, which must include descriptions of Contractor shall have policies and procedures that describe’s~~ contingency plans for unexpected peak ~~transportation~~Transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service. ~~The~~ Contractor shall ensure that NEMT ~~providers~~Providers arrive on time for scheduled pick-ups. The NEMT ~~provider~~Provider may arrive before the scheduled pick-up time, but the ~~member~~Member may not be required to board the vehicle prior to the scheduled pick-up time.

(14) ~~(11)~~-Pick up and Delivery

~~(a) — The, which must include Contractor shall ensure ensuring that drivers;~~

(a) Drivers make their presence known to ~~the member~~Members and require drivers to wait until at least ~~fivetwenty~~ (520) minutes after the scheduled pick-up time. If the ~~member~~Member is not present ~~fivetwenty~~ (520) minutes after the scheduled pick-up time, the driver must notify the dispatcher before departing from the pick-up location.;

(b) ~~The Contractor shall ensure that drivers~~Drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).;

(c) ~~The Contractor shall ensure that members~~Members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, ~~the~~ Contractor shall ensure that ~~members~~Members are picked up within one (1) hour after notification. Pick-up and drop-off times should be captured in such a way to allow reporting as requested by OHA. Members may not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members may not be dropped off for their appointment before the ~~provider~~Provider’s office or facility has opened its doors.—; and

- (d) The ~~Contractor shall ensure that the~~ waiting time for ~~members~~ Members for pick-up does not exceed ~~ten~~ twenty (~~10~~ 20) minutes past the scheduled pick-up time. Scheduled pick-up times shall allow the appropriate amount of travel time to assure the ~~members~~ Members arrive giving them sufficient time to check-in for their appointment. Members shall be dropped off for their appointment no less than fifteen (15) minutes prior to their appointment time to prevent the drop off time from being considered a late drop off.

(15) Accidents and Incidents, which must require Contractor or the NEMT Provider, upon becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver (individually and collectively, an “Incident”) to provide OHA with Administrative Notice of the Incident. Such Administrative Notice shall be made as follows:

(a) Within twenty-four (24) hours of the Contractor becoming aware of the Incident to the following email address:

(b) Describe the Incident with particularity including, without limitation: (i) the name of the driver, (ii) the name of the passenger, (iii) the location of the Incident, (iv) the date and time of the Incident, (v) a description of the Incident and any injuries sustained as a result of the Incident, and (vi) whether the driver or the passenger required treatment at a Hospital.

(c) Include, if applicable, a police report number with such Administrative Notice, or shall provide the full police report to OHA as soon as possible after providing Administrative Notice of the Incident.

(d) Contractor shall cooperate in any related investigation.

(16) ~~(12) Monitoring and Documentation of services~~ ~~(a)~~, which require Contractor ~~shall~~ to:

(a) Subject to OAR 410-141-3485, collect and maintain documentation of services provided that includes each trip, the Member ID, the destination, the reason the ride was requested (service reason), and any incidents of no-show on part of the driver or the ~~member~~ Member;

(b) ~~Contractor shall~~ Subject to the requirements set forth in OAR 410-141-3435, pay for coordination and provision of NEMT Services provided ~~for~~ to 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.;~~

(c) Monitor and document complaints about NEMT Services, including those relating to any incidence of a driver failing to show up for a requested transport. Any and all instances of a driver failing to show up for a requested transport shall require documented follow up from the Contractor’s NEMT coordinator or designee. Required follow up includes determining whether the Member suffered any harm as a result of the driver’s failure to provide the ride, whether rescheduling of appointments was or is necessary, and whether any additional recourse or Corrective Action with the driver or the Subcontracted NEMT Provider is appropriate.

e. ~~(13) NEMT Call Center Operations.~~

- (1) ~~(a)~~ In addition to its NEMT Services policies and procedures, Contractor shall maintain a NEMT Call Center to handle requests for NEMT ~~services~~Services as well as questions, comments, and inquiries from ~~members~~Members and their representatives, NEMT ~~providers~~Providers, and ~~providers~~Providers regarding NEMT ~~services~~Services. The NEMT Call Center may use the same infrastructure as the Contractor's ~~member~~Member services line, but ~~the~~ Contractor shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.
- (2) ~~(b)~~ The NEMT Call Center shall operate at a minimum, Monday through Friday from 9:00 a.m. to 5:00 p.m., but the brokerage Contractor may close the call center on New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas. The Authority may approve, in writing, additional days of closure if the Contractor requests the closure at least thirty (30) days in advance. Notwithstanding the foregoing limitations on the operation of Contractor's NEMT Call Center, Contractor must still make NEMT Services available to its Members four (24) hours a day, three hundred and sixty-five (365) days a year as set forth under Sub. Para. (6)(a) above of this Para. b, Ex. B, Part 2.
- (3) ~~(c)~~ For hours that the Contractor is using may use alternative arrangements to handle NEMT calls during hours outside of those in the preceding paragraph. During any hours when the NEMT Call Center is closed, the Contractor shall provide an after-hours message in, at a minimum, English and Spanish instructing the caller. The message must explain how to access the alternative arrangement (not requiring, in a manner that does not require the Member to place a second call) and. The outgoing message must also offering offer the caller the opportunity to leave a message utilizing a process in which all messages are returned within the next business day and efforts continue until the member is reached provided that the. If the Member's message left by the enrollee is discernible and includes a valid phone number in which for the enrollee can be contacted Member, the Contractor must respond to the message within the next Business Day, with efforts continuing until the Member is reached. All efforts made to reach a ~~member~~Member who has left a message shall be documented in order to demonstrate compliance with this requirement.
- (4) ~~(d)~~ Contractor's NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller's phone number is not blocked. Contractor The NEMT Call Center shall have the capability of making outbound calls. The NEMT Call Center shall provide a mechanism for advising Members, when all schedulers are busy assisting other Members with scheduling Transportation, (i) approximate wait times, (ii) such Member's line-up in the caller queue, and (iii) provide the option for call backs without such Members from losing their place in the queue. Contractor shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed and the following performance standards are met for each line or queue:
- (a) ~~i.~~ Answer rate – At least eighty-five percent (85%) of all calls are answered by a live voice within thirty (30) seconds;
- (b) ~~ii.~~ Abandoned calls – No more than five percent (5%) of calls are abandoned; and
- (c) ~~iii.~~ Hold time – Average hold time, including transfers to other Contractor staff, is no more than three (3) minutes.

- (5) ~~(e)~~ If a NEMT call cannot be answered by a live voice within thirty (30) seconds, ~~the~~ Contractor shall provide a message in, at a minimum, English and Spanish, advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message ~~requests~~asks the Contractor to return the call and includes a valid phone number for the Member, the Contractor shall promptly return the call within three (3) hours ~~and continue~~, continuing the effort until the ~~member~~Member is reached ~~provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted~~. All efforts made to reach a ~~member~~Member who has left a message shall be documented in order to demonstrate compliance with this requirement.
- (6) ~~(f)~~ Contractor shall have qualified bi-lingual/multilingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers ~~who, at a minimum, speak Spanish, the~~. The Contractor shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency. Contractor's NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.
- (7) ~~(g)~~ Contractor shall operate an automatic call distribution system for its NEMT Call Center. Contractor shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking ~~member~~Member queue, a Spanish-speaking ~~member~~Member queue, a NEMT ~~provider~~Provider queue, and a ~~provider~~Provider healthcare queue. The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt allowing the Member to opt into the appropriate queue.
- (8) ~~(h)~~ Contractor shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the ~~member~~Member's eligibility for NEMT ~~services~~Services, the appropriate mode of ~~transportation~~Transportation, the purpose of the trip and all other pertinent information relating to the trip ~~(see Section A.4 of this Attachment)~~. The Contractor may develop additional scripts for other types of NEMT calls from ~~members~~Members, healthcare ~~providers~~Providers, and NEMT ~~providers~~Providers. Any script for use with ~~an enrollee~~a Member shall be written at the sixth (6th) grade reading level and must ~~be prior~~have been pre- approved in writing by OHA, which must be provided to OHA via Administrative Notice. Contractor shall advise callers that calls to the NEMT Call Center are ~~monitored~~Monitored and recorded for quality assurance purposes.
- (9) ~~(i)~~ Contractor shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity, and training purposes. Contractor shall ~~monitor~~Monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff ~~member~~Member on a monthly basis. ~~The~~ Contractor shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. ~~The~~ Contractor shall use this ~~monitoring~~Monitoring to identify problems or issues, for quality control, and for training purposes. ~~The~~ Contractor shall document and retain results of this ~~monitoring~~Monitoring and subsequent training.
- (10) ~~(j)~~ Contractor's NEMT Call Center system ~~shall be able to~~must collect and document data and produce ~~the quarterly and ad hoc~~ reports required under ~~the contract and ad hoc reports that OHA may request~~. ~~Contractor shall analyze data collected from its NEMT~~

~~Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Contract, and ensure adequate resources and staffing, both this Contract and OAR 410-141-3485 as set forth in further detail in Para. f below of this Sec. 5, Ex. B, Part 2.~~

f. ~~(14)~~ NEMT Quality Assurance Program

(1) As part of the Contractor's ~~Compliance Plan~~compliance plan required by the Contract, ~~the~~ Contractor shall develop written policies and procedures outlining the activities for ongoing ~~monitoring~~Monitoring, evaluation and improvement of the quality and appropriateness of NEMT ~~services~~Services. ~~OHA shall have the right to request, via Administrative Notice made to Contractor's Contract Administrator, Contractor's policies and procedures for review and approval. Contractor shall provide, in accordance with OHA's request, such policies and procedures to OHA within five (5) Business Days of OHA. In the event OHA does not approve Contractor's compliance policies and procedures, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract.~~

(2) The NEMT Quality Assurance Plan shall include at least the following:

- (a)** Contractor's procedures for ~~monitoring~~Monitoring and improving ~~member~~Member satisfaction with NEMT ~~services~~Services must include, without limitation:
 - i.** Processes for accepting NEMT complaints from Members and from others acting on Members' behalf, including medical Providers, as set forth in Sub. Para (1), Para. d, of Sec. 5 above of this Ex. B, Part 2; and
 - ii.** Processes for conducting Member satisfaction surveys on a regular basis. Follow up Member satisfaction surveys must be sent to, and collected from, a minimum of ten percent (10%) of all Members who scheduled NEMT rides.
- (b)** Contractor's procedures for ensuring that all NEMT ~~services~~Services paid for are properly approved and actually rendered, including but not limited to validation checks and an annual analysis matching physical health and ~~behavioral health~~Behavioral Health claims/encounters and NEMT claims/encounters;
- (c)** Contractor's procedures for ~~monitoring~~Monitoring and improving the quality of ~~transportation~~Transportation provided pursuant to the Contract, including ~~transportation~~Transportation provided by fixed route; and
- (d)** Contractor's ~~monitoring~~Monitoring plan for NEMT ~~providers~~Providers to ensure compliance with OARs 410-141-3435 through 410-141-3485, which shall include, without limitation, policies and procedures for:

~~(15)~~—NEMT Reports—

- i.** Verifying and documenting drivers have the necessary, current State vehicle registrations and State driver's licenses at the time of service provision;

- ii. Verifying that provider vehicles are accessible for Members, including those Members with disabilities, or other Special Health Care Needs (e.g., wheelchair restraints for wheelchairs, etc.);
 - iii. Conducting, and maintain documentation of, background checks at regular intervals on all drivers including criminal history, driver history, sex offender status, and drug testing;
 - iv. Providing, or ensuring that drivers have attended, and documentation thereof, appropriate training for the level of services being provided (e.g., door to door vs. curbside to curbside), how to assist Members with disabilities, and other Special Health Care Needs, and how to serve passengers in a culturally aware manner.
 - v. Verifying, and documentation thereof, NEMT Service Subcontractors have and maintain appropriate workers compensation, general liability, and automotive liability insurance; and
 - vi. Auditing and documentation thereof, a percentage of daily rides for claims data, pick-up, and drop off times, appropriate level of transport, and Member satisfaction.
- (3) As part of its NEMT Quality Assurance Plan, Contractor shall collect data and submit a quarterly report that provides a summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received, using the NEMT Quality Assurance Quarterly Reporting Template, quarterly reports to OHA relating to Contractor's NEMT Call Center operations. the NEMT Quality Assurance Quarterly Reporting Template is located on the CCO Contract Forms Website. Such quarterly data reporting shall not be delegated by Contractor to a third-party. Contractor is responsible for validating and submitting all NEMT Call Center quarterly reports. All such data collection and documentation is subject to the requirements set forth in OAR 410-141-3180.
- (a) Contractor's NEMT Quarterly Report shall be provided to OHA via Administrative Notice by no later than ninety (90) days after the end of each calendar quarter. The quarterly report must include, at a minimum, specifics regarding:
- i. Call volume, during regular business hours and ~~total calls received~~ after business hours
 - ii. Call wait times, including the average wait time.

~~(16) Accidents and Incidents~~

~~Immediately upon the Contractor or the subcontracted vendor becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver that occurs while providing services under the Contract, the Contractor shall notify OHA. Contractor shall submit a written accident/incident report within five (5) business days of the accident/incident and shall cooperate in any related investigation. A police report shall be included in the accident/incident report or provided as soon as possible.~~

~~(17)~~ **NEMT Complaints**

~~Contractor shall monitor NEMT complaints and document any incidence of a driver failing to show up for a requested transport. Any incidence of a driver failing to show up for a requested transport shall require documented follow up from the Contractor's NEMT Coordinator or designee. Required follow up includes determining whether the member suffered any harm as a result of the driver's failure to provide the ride, whether rescheduling of appointments is necessary, and whether any additional recourse or corrective action with the Subcontractor is appropriate.~~

iii. Calls answered,

iv. Call resolution,

v. Types of calls, and

vi. Percentage of call hang-ups.

(b) Contractor shall analyze data collected from its NEMT Call Center system and any other data required to be collected and documented under this Sec. 5 of Ex. B, Part 2 as is necessary to perform quality improvement, fulfill the reporting and Monitoring requirements as required under this Contract, and ensure adequate resources and staffing.

g. OHA has the right to request, and Contractor shall provide OHA, with all NEMT documentation, information, reports, phone call recordings, complaints submitted, policies and procedures, systems, facilities that provide or otherwise relate to NEMT services for purposes of determining compliance with the terms and conditions of this Ex. B, Part 2 and other applicable provisions of this Contract.

6. ~~e.~~ Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care

a. ~~(1)~~ Contractor shall provide preventive services, defined as 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, and 410-141-0480, and 410-141-0520. Such ~~(5)~~.

(1) Preventative services include, but are not limited to, periodic medical examinations and screening tests based on age, gender and other risk factors; ~~screening tests; screenings,~~ 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, to the extent that they are Covered Services, all necessary diagnosis and treatment services that are identified as a result of such screening to the extent such services are Covered Services providing Member preventive service screenings. To the extent ~~such~~ that any necessary diagnosis and treatment services are required that are identified as a result of providing Member preventative service screenings, and such subsequent diagnosis and treatment services are Non-Covered Services, but are ~~Medical~~ nonetheless Case Management Services (whether dental, Behavioral, physical, or other services), Contractor must: (i) refer the Member all such affected Members to an appropriate

Participating or Non-Participating ~~Provider~~Providers, and ~~(ii)~~ manage and coordinate the services for all such Members.

- (2) Contractor shall Monitor all Members and send preventive service reminders annually to both (i) Members who have not received preventative services and (ii) such Members' PCPs.
- (3) For ~~Preventive—Services~~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. OHA shall have the right to require Contractor to participate in specific preventative service programs as part of its Quality Improvement Program as more fully set forth in Ex. B, Part 10 of this Contract.~~

b. ~~d.~~ **Family Planning Services**

Members may receive Covered Services for Family Planning Services from any OHA Provider as specified in the Social Security Act, Section 1905 [42 U.S.C. 1396d], 42 CFR §431.51 and as defined in OAR 410-120-0000 and 410-130-0585. To the extent ~~the Member chooses~~Members choose 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.

c. ~~e.~~ **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 through 441.259 and the requirements of OHA established in OAR 410-130-0580.
- (2) Member Representatives ~~may do~~ not have the right to give consent for sterilizations. All consents must comply with the criteria set forth in OAR 410-130-0580.
- ~~(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) Copies of all signed informed consents for sterilization and hysterectomies must be provided to OHA via Administrative Notice prior to the performance of the procedure..
- (4) ~~(3) In the event~~ OHA ~~will notify~~learns that one or more of Contractor's Members has received a hysterectomy or sterilization service prior to receipt of Contractor's Administrative Notice under Sub. Para (3) of this Para. c to this Sec. 6, Ex. B, Part 2 OHA will, no later than thirty (30) days past the end of each calendar quarter ~~of~~, provide Contractor's Encounter Data Liaison with Administrative Notice of such services and the

names of Members who received ~~a hysterectomy or sterilization service~~ such Services. Contractor ~~in turn~~ shall ~~supply the informed consent then,~~ within thirty (30) days of notification to the Contractor's designated Encounter Data Liaison such Administrative Notice, provide, as set forth in OHA's Administrative Notice, the informed consent forms for all Members identified therein by OHA.

- (5) ~~(4)~~ OHA in collaboration with Contractor ~~reconciles~~ shall reconcile all hysterectomy or sterilization (or both) services with informed consents with the associated ~~encounter-claims~~ Encounter Data by either:
- (a) Confirming the validity of the consent and ~~notifying~~ providing Contractor's Encounter Data Liaison via Administrative Notice that no further action is needed;
 - (b) ~~Requesting a~~ Advising Contractor's Encounter Data Liaison via Administrative Notice that OHA requires Contractor to provide corrected informed consent form forms to be provided to OHA as set forth in such Administrative Notice; or
 - (c) ~~Informing~~ Providing Contractor ~~the's~~ Encounter Data Liaison with Administrative Notice that informed consent is form(s) are missing or invalid and ~~Provider~~ Contractor must ~~reoup the payment~~ return all Payments received for such procedures in accordance with Sub. Para. (6) below of this Para. c, Sec. 6, Ex. B, Part 2 and must change the associated ~~encounter-claim~~ Encounter Data to reflect no payment made for service(s).
- (6) ~~(5)~~ In the event Contractor fails to comply with the requirements of this Para. c, Sec. 6, Ex. B, Part 2 but is nonetheless receives Payment for such procedures, such Payment will be subject to deemed an Overpayment recovery and subject to reporting and return in accordance with Sec. 11, Para. b, Sub.Paras. (15)-(17) and Sec. 15 of Ex. B, Part 9 or set-off as described set forth in Exhibit D, Section 7 Sec. 7, Ex. D of this Contract for failure to comply with the requirements of this section.

d. ~~f.~~ Post Hospital Extended Care (PHEC) Coordination

- (1) PHEC is a twenty (20)-day benefit included within the Global Budget ~~payment~~ Payment. Contractor shall make the benefit available ~~for to~~ non-Medicare Members who meet Medicare criteria for a post-~~hospital~~ Hospital skilled Nursing Facility placement.
- (2) Contractor shall notify the Member's local DHS ~~APD~~ ADP office as soon as the Member is admitted to PHEC. ~~The~~ Upon receipt of such notice, Contractor and the Member's APD will office must promptly begin appropriate discharge planning.
- (3) Contractor shall notify the Member and the PHEC facility of the proposed discharge date from such PHEC facility no ~~later~~ less than two full days prior to discharge.
- (4) Contractor shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to DME, medications, home and Community based services, discharge education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to: (i) attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need, or (ii) schedule follow-up care appointments with Providers that the Member may need to see, (iii) or both (i) and (ii).

- (5) ~~(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~~www.medicare.gov/publications
- (6) ~~(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~~PHEC facility placement.

7. ~~g.~~ Covered Service Components: Medication Management

- a. ~~(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~~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~~FBDE 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. Prescription drugs covered by ~~the~~ Contractor ~~shall~~must be ~~made available~~listed on Contractor's website ~~in a machine-readable format~~.
- (1) To ensure FBDE Members receive appropriate medications necessary for treatment of physical or Behavioral Health conditions, Contractor shall coordinate with FBDE Members MA and DSPN Plans or Part D Plans to ensure Members are connected to Medicare medication management services.
- b. ~~(2)~~ ~~Contractor shall operate a Drug Use Review (DUR) program that meets the definition and standards in 42 CFR §438.3. Contractor shall~~ In addition to the requirements of its DUR Program as set forth in Sec. 1, Para. g above of this Ex. B, Part 2, Contractor must also participate and coordinate response to CMS annual DUR Drug Utilization Review survey, for reporting period October 1, 2018-September 30, 2019—, which is located on the CCO Contracts Form Website. Contractor shall ~~submit~~provide such completed survey to; OHA ~~CCO Contract Administrator, via Administrative Notice, by no later than~~ June 1, 2020 ~~and~~. Contractor shall be required to participate in, coordinate with, and respond to any future CMS DUR Drug Utilization Review survey inquiries that may be conducted from time to time.
- c. ~~(3)~~ Contractor shall develop and maintain written 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. Such policies and procedures shall require Contractor ~~shall~~to prioritize service coordination and the provision of other mental health services and supports for these children. Contractor shall provide, OHA via Administrative Notice, with such policies and procedures within five (5) Business Days of request by OHA.
- d. ~~(4)~~ Requirements for Oregon Prescription Drug Program; Agreements with Pharmacy Benefit Managers.
- (1) Pursuant to OAR 410-141-XXXX Contractor may contract with the OPDP to provide PBM services. Contracting with the OPDP is deemed to satisfy the requirements under OAR 410-141-XXXX.
- (2) In the alternative, Contractor may subcontract for PBM services provided that its Subcontracts with its PBM include, in addition to those requirements set forth in Sec. 12

of Ex. B, Part 4 of this Contract, all of the provisions in this Para. d, Sec. 7, Ex. B, Part 2 and all of the criteria set forth in OAR 410-141-XXXX (2)-(3). Subject to the foregoing, Contractor must contractually require, without limitation, its PBM to do all of the following:

- (a) ~~Contractor shall ensure that contracts with Pharmacy Benefit Managers meet requirements related to transparency, rebate pass back, cost pass-through at 100%, reporting of administrative fees and of pharmacy paid amounts at a claim level.~~Incorporate all of the State and federal laws relating to PBM services and transparency;
- (b) ~~Contractor shall obtain third party market check and audit on an annual basis to ensure PBM is compliant with requirements and is market competitive. This third party market check and audit shall:~~Pass through 100% of pharmacy costs such that a claim level audit will clearly show that payments made to a pharmacy by the PBM matches the amount the Contractor has paid to the PBM;
- ~~i. Be completed and delivered to Contractor by July 1 each year (beginning in 2021) and subsequently shared with the Oregon Health Authority within 7 days of delivery;~~
- ~~ii. Clearly identify the comparator data used as a benchmark for this market check and the current performance of the PBM~~
- (c) ~~Contractor shall include language within its Pharmacy Benefit Management contract that the PBM agreement is subject to renegotiation based on the market check report findings, and includes the following contractual provisions:~~Pass through all rebates and other utilization-based payments made to the PBM by the manufacturers
- (d) Require the renegotiation of and amendment to the Subcontract with Contractor whenever a third-party market check determines the PBM's performance is more than one percent (1%) behind the current market in terms of aggregated savings. Accordingly, the Subcontract with Contractor's PBM must include the following specific provisions:
- ~~i. i.~~ If the market check report finds that current market conditions can yield “in the aggregate” gross plan pharmacy cost savings (defined as eligible charges plus base administrative fees) from three quarters of a percent (0.75%) to ninety-nine one hundredths of a percent (0.99%), the parties may elect to initiate discussions to review the existing pricing terms and other applicable provisions under the PBM ~~Agreement~~contract to establish whether an adjustment should be considered.
- ~~ii. ii.~~ If the market check report finds that current market conditions can yield “in the aggregate” gross plan pharmacy cost savings of a one percent (1.0%) or more, the parties shall ~~negotiate in good faith and~~ execute a ~~revision~~an amendment to the existing pricing terms and other applicable provisions under the PBM ~~Agreement~~contract within ~~thirty (30)~~ thirty (30) days, to be effective on the later of ~~thirty (30)~~ thirty (30) days post signature or by no later than October 1st of the evaluation year.

- (a) Include confidentiality provisions in all of its subcontracts and amendments thereto;
- (b) Provide reports that detail services at the claim level;
- (c) Make an attestation of financial and organizational accountability and also its commitment to the principle of transparency;
- (d) ~~No spread PBM contracting requirement does not preclude a pay for performance model contract. If utilizing a pay for performance contract with its PBM, Contractor shall ensure that the terms of that contract must be transparent and understood by OHA. If seeking to use a pay for performance PBM contract, Contractor shall submit the model contract to OHA for approval before implementation.~~ Permit Contractor or OHA, or both of them to have access to: (x) financial statements upon request, and (y) the PBMs' officers who have knowledge of the strategic, financial, and operational relationships and business transactions that may directly or indirectly affect performance under the Subcontract with Contractor; and
- (e) Require full, clear, complete, and adequate disclosure to Contractor and OHA the services provided and all forms of income, compensation, and other remuneration it receives and pays out or expects to receive or pay out under the Subcontract with Contractor.
- (f) Allow Contractor to perform audits on an annual basis (and which Contractor must perform subject to Sub. Para. (9) below of this Para. d, Sec. 7, Ex. B, Part 2) to ensure its PBMs are compliant with requirements and are market competitive. This third-party market check and audit must:
- i. Be completed and delivered to Contractor by July 1 each year (beginning in 2021) and subsequently shared with OHA within seven (7) days of delivery to Contractor, which shall be made via Administrative Notice; and
 - ii. Clearly identify the comparator data used as a benchmark for the market check and the current performance of each PBM.
- (3) No-spread PBM contracting requirements do not preclude Contractor to enter into a pay for performance model contract. However, if Contractor desires to use a pay for performance contract with its PBM, Contractor must provide OHA with Administrative Notice of such intent and include the proposed model pay for performance contract with such Administrative Notice. OHA will review Contractor's model pay for performance contract for compliance with this Sub Para. (5), para. d, Sec. 7, Ex. B, Part 2 and provide Contractor's Contract Administrator with Administrative Notice of its approval or disapproval of Contractor's model contract within thirty (30) days of receipt. In the event OHA disapproves of Contractor's model contract, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract. In no event shall Contractor enter into a pay for performance contract with any PBM prior to receipt of OHA's Administrative Notice of approval.

- (4) ~~(e)~~ Contractor ~~shall~~must, and any Subcontract with a PBM ~~must~~, require the PBM to, align its prescription drug formulary with the ~~fee~~Fee-for-service Service Preferred Drug List (~~PDL~~) for any and all medications in drug classes required by OHA.
- ~~(f)~~ ~~Contractors's Requirements for PDL~~ Such alignment must include:
- (a) ~~i.~~ Identical preferred and non-preferred status; and
- (b) ~~ii.~~ Identical criteria for ~~prior authorization~~Prior Authorization for all medications on the PDL
- (5) Contractor must, and any Subcontract with a PBM must require thw PBM to, adopt Preferred Drugs as identified and directed by OHA's pharmacy and therapeutics committee.
- (6) Contractor's prescription drug formulary must be updated in a timely manner and such updates must be publicly posted concurrently therewith.
- (7) Contractor must submit on January 15, 2020 and again within five (5) Business Days of any update in a format required by OHA, via Administrative Notice, its:
- (a) PDLs for all classes to OHA in a format required by OHA; and
- (b) Coverage criteria for all non-aligned PDL classes.
- (8) ~~(g)~~ ~~Information~~Contractor must publicly post information on Contractor's prescription drug formulary, including coverage and ~~PA~~prior approval criteria, ~~shall be publicly.~~ Such information must, when posted ~~and, be made~~ readily accessible by patients, prescribers, dispensing pharmacies, and OHA staff. ~~Contractor's prescription drug formulary shall be updated in a timely manner prior to implementing changes made to either coverage or PA criteria.~~
- (9) In the event Contractor does not audit its PBM annually, then Contractor must perform an annual third-party market check as required under OAR 410-141-XXXX.

8. Covered Service Components: Other Services

a. ~~h.~~ Intensive Care Coordination

~~(1)~~ Contractor is responsible for providing, in addition to general Coordinated Care Services, Intensive Care Coordination services. ~~This section sets forth~~Contractor must provide Intensive Care Coordination in accordance with the ~~elements and~~ requirements ~~for~~set forth in OAR 410-141-3170, this Para. a., Sec. 8, Ex. B, Part 2, and as may be provided for elsewhere in this Contract. Without limiting the foregoing, Contractor's Intensive Care Coordination ~~services~~ must include:

- (1) Making available Trauma Informed, Culturally and Linguistically Appropriate Intensive Care Coordination Services, without the requirement of an assessment, to Members who are expressly identified in OAR 410-141-3170(2)(a)-(o) and those identified in Exhibit B, Part 4, Sec. 10, Para. a, Sub. Para. (1)(a) of this Contract.
- (2) ~~Contractor shall make trauma informed, culturally responsive and linguistically appropriate Intensive Care Coordination Services available to Members identified as aged, blind, or disabled, Members with Special Health Care Needs, Members who are part of a Prioritized Population, 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 Care Coordination services may be requested by the Member, the Member Representative, Physician, other medical personnel serving the Member, or the Member's agency case manager. Providing Trauma Informed, Culturally and Linguistically Appropriate Intensive Care Coordination Services and Behavioral Health Services to children and adolescent Members according to presenting needs.~~

- ~~(3)~~ (3) Providing Trauma Informed, Culturally and Linguistically Appropriate Intensive Care Coordination Services to Members receiving Medicaid funded home or Community Based Settings for Long Term Care Services and Supports under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver.
- ~~(4)~~ (4) Offering Trauma Informed, Culturally and Linguistically Appropriate Intensive Care Coordination Services if qualified by an assessment.
- ~~(5)~~ (3) ~~Contractor shall respond~~Responding to requests for Intensive Care Coordination services with an initial response by the next Business Day following the request.
- ~~(6)~~ (4) ~~Contractor shall periodically inform~~Periodically informing all Participating Providers of the availability of Intensive Care Coordination services, ~~provide~~providing training ~~for~~to PCPCHs and other ~~PCP's~~PCPs staff ~~on~~regarding the Intensive Care Coordination services and other support services available ~~for~~to Members.
- ~~(7)~~ (7) Ensuring that a Member's DHS Area Agency on Aging/Aging and People with Disabilities, Office of Developmental Disability Services, Long Term Care, or Long Term Services and Supports case manager, have a direct method to contact the Member's ICC Care Coordination team.
- ~~(8)~~ (5) ~~Contractor shall assure~~Ensuring that the Member's case manager's name and telephone number are available to agency staff and Members or Member Representatives when Intensive Care Coordination services are provided to the Member.
- ~~(9)~~ (6) ~~Contractor shall make~~Making Intensive Care Coordination 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.
- ~~(10)~~ (10) Providing prioritized Intensive Care Coordination services to Members who are children and adolescents in the custody of DHS as provided for in Ex. B, Part 4, Sec. 10, Para. a., Sub. Para. (1)(a) of this Contract.
- ~~(11)~~ (7) ~~Additional Intensive Care Coordination responsibilities are outlined in~~set forth Sec. 10, para. a, of Ex. B, Part 4, and Exhibit M of this Contract.

i. b. Tobacco Cessation

Contractor shall provide ~~for: culturally responsive and linguistically appropriate~~Culturally and Linguistically Appropriate tobacco dependence Assessments, ~~systematically and on-going;~~ and cessation intervention, treatment, and counseling services. Such services must be provided on a systematic and on-going basis that is consistent with recommendations listed in the Tobacco Cessation standards located at: <http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Docum>

~~[ents/tob_cessation_coverage_standards.pdf](http://www.oregon.gov/oha/PH/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_coverage_standards.pdf)~~

~~http://www.oregon.gov/oha/PH/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_coverage_standards.pdf~~

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~~Evidence-Based Community Standards, the national standard, or as ~~outlined in~~set forth under OAR 410-130-0190.

c. ~~j.~~ 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~~Para. c. of this Sec. 8, Ex. B, Part 2, “primary treating health professional” means a ~~health care professional~~Health Care Professional responsible for the treatment of the breast or cervical cancer. OHA ~~may monitor encounter data~~has the right to Monitor Encounter Data to identify these Members who have ceased receiving treatment services. Contractor shall respond to OHA requests for the primary 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.

d. ~~k.~~ Oral Health Services

- (1) Contractor shall provide to Members all ~~oral health~~Oral Health Covered Services within the scope of the Member’s Benefit Package of Dental Services, in accordance with the terms of this Contract and as set forth in OAR Chapter 410 Division 141 applicable to ~~DCOs and with the terms of this Contract~~Dental Care Organizations.
- (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~~10) and (~~15~~d). 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~~Hospital setting.
 - (a) For routine ~~oral health~~Oral Health care, the Member shall be seen within eight weeks unless there is a documented special clinical reason which would make access longer than eight weeks appropriate. Routine ~~oral health~~Oral Health treatment or treatment of incipient decay does not constitute emergency care.
 - (b) ~~For~~Subject to OAR 410-141-3220(10)(d)(A) and (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~~one to two weeks or earlier 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.

9. ~~5.~~ Non-Covered Health Services with Care Coordination

- a. Except as provided in Sec. 10 below of this Ex. B, Part 2, Contractor shall coordinate services for each Member who requires health services not covered under ~~the CCO Payment~~this Contract.
- b. Contractor shall assist its Members in gaining access to certain ~~behavioral health~~Behavioral Health services that are not Covered Services ~~and that~~but which are provided under separate contract with OHA, including but are not limited to the following:
- (1) 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;
 - (2) Therapeutic ~~Foster Care~~foster care reimbursed under ~~HCPCS~~Healthcare Common Procedure Coding System, Code S5146, for Members under 21 years of age;
 - (3) Therapeutic group home reimbursed for Members under 21 years of age;
 - (4) Behavioral rehabilitative services that are financed through Medicaid and regulated by DHS Child Welfare and ~~OYA~~Oregon Youth Authority;
 - (5) Investigation of Members for Civil Commitment;
 - (6) Long Term Psychiatric Care (~~LTPC~~) for Members 18 years of age and older;
 - (7) Preadmission Screening and Resident Review (~~PASRR~~) for Members seeking admission to a LTPC;
 - (8) ~~Long Term Psychiatric Care (LTPC)~~ for Members age 17 and under, including:
 - a. ~~(a)~~ Secure Children's Inpatient program (~~SCIP~~),
 - b. ~~(b)~~ Secure Adolescent Inpatient Program (~~SAIP~~), ~~or~~and
 - c. ~~(c)~~ Stabilization and transition services (~~STS~~);
 - (9) Personal care in adult foster homes for Members 18 years of age and older;
 - (10) Residential mental health services for Members 18 years of age and older provided in licensed ~~community~~Community treatment programs;
 - (11) Abuse investigations and protective services as described in OAR 407-045-0000 through 407-045-0370 and ORS 430.735 through 430.765; and
 - (12) Personal Care Services as described in OAR 411-034-0000 through 411-034-0090 and OAR 309-040-0300 through 309-040-0330.

10. ~~6.~~ Non-Covered Health Services without Care Coordination

Non-Covered Services for which Contractor ~~does is~~ not ~~need~~required to provide ~~care coordination~~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. Hospice services for Members who reside in a skilled Nursing Facility;
- c. Long term care services excluded from Contractor reimbursement pursuant to ORS 414.631;
- d. School-~~based services~~Based Health Services that are Covered Services provided in accordance with Individuals with Disabilities Education Act (~~IDEA~~) requirements that are reimbursed with the educational services program;

- e. Administrative examinations requested or authorized in accordance with OAR 410-130-0230; and
- f. Services provided to ~~CAWEM~~Citizen/Alien Waived Emergency Medical recipients or CAWEM Plus-CHIP Prenatal Coverage for CAWEM.
- g. Out-of-Hospital birth services including prenatal and postpartum care for women meeting criteria defined in OAR 410-130-0240(4) provided that such women have an established relationship with a licensed practitioner who is a Non-Participating Provider of Contractor, in which case services will be provided by such licensed practitioner for up to sixty (60) days after the date of delivery.

~~Exhibit B –Statement of Work - Part 3—~~

Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement ~~and Activation~~in Member Health Care and Treatment Plans

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 how it:

- a. Uses Community input and the Community Health Assessment (~~CHA~~) process to help determine the most ~~culturally responsive and linguistically appropriate~~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 its Provider Network about the availability, scope of practice, and the benefits of THW Services. Such education should include, without limitation, how such THW services are integrated into Contractor's health system and how THWs can be incorporated into a Member's primary care team.
- d. ~~e.~~ Educates Members on how to navigate the coordinated and integrated health system developed by Contractor by means that may include Traditional Health Workers as part of the Member's primary care team;
- e. ~~d.~~ Encourages Members to make healthy lifestyle choices and to use wellness and prevention resources, including ~~mental health~~Behavioral Health and addictions treatment, culturally-specific resources provided by ~~community-based~~Community-Based organizations and service ~~providers;~~Providers;
- f. Works with Providers to develop best practices for care and delivery of services to reduce waste, and improve health and well-being of all members which includes ensuring Members have a choice of providers within Contractor's network, including those who can provide culturally and linguistically appropriate services;
- g. ~~e.~~ Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy to inform Members of rights and responsibilities; and
- h. ~~f.~~ Meaningfully engages the ~~CAC~~Community Advisory Council to ~~monitor~~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 written 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~~OHA certified or ~~Qualified Health Care Interpreter~~qualified health care interpreter services available free of charge to each Potential Member and Member. This applies to all non-English languages and sign language, not just those that OHA identifies as prevalent-~~Contractor shall notify its Members and, Contractor shall notify its Members,~~ Potential Members, and Provider Network that oral and sign language interpretation ~~is~~services are available free of charge for any spoken language and sign language and that written information is available in prevalent non-English languages in Service Area(s) as specified in 42 CFR §438.10(d)(4)-~~Contractor shall notify its Members, Contractor shall notify Potential Members and Members in its Member Handbook, Marketing Materials, and other Member materials, and its Provider Network in Contractor's new hire or other on-boarding materials and other communications, about~~ how to access oral and sign language 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~~the Member's own 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~~Prepaid Health Plan, any limitation the Contractor imposes on ~~his or her~~Member's freedom to change between ~~PCPs~~Primary Care Providers or to obtain services from Non-Participating Providers if the service or type of ~~provider~~Provider is not available with the Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Sec. 9, below of this 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: (i) be actively involved in the development of Treatment Plans if Covered Services are to be provided and to, (ii) participate in decisions regarding such Member's own health care, including the right to refuse treatment; (iii) and have the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or Behavioral Health treatment, (iv) execute directives and powers of attorney for health

care established under ORS 127.505 to 127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act, and (v) have Family involved in such treatment planning;

- j. Allow each Member the right to request and receive a copy of ~~his or her~~Member's 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)(2)-(3), and 42 CFR §438.10(g), if applicable, as specified in the CFR within thirty (30) days after the Contractor receives 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.
 - (1) In instances where Contractor's Members have obtained an MA or DSN Plans through one of Contractor's Affiliates, Contractor may choose to send integrated Medicare and Medicaid materials such as a Medicare/Medicaid summary of benefits and Provider directories.
- l. Ensure that each Member has 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~~the Member's 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, or behavioral 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.~~
- ~~o.~~ p. Ensure, and cause its Participating Providers to ensure, that each Member is free to exercise ~~his or her~~Member's 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.
- ~~p.~~ q. Ensure that any cost sharing authorized under this Contract for Members is in accordance with 42 CFR §447.50 through 42 CFR §447.90 and ~~with~~ the General applicable Oregon Administrative Rules.
- ~~q.~~ r. Notify Members of their responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230.
- ~~r.~~ s. If available and upon request by Members, utilize electronic methods ~~of communications with Members, at their request, to~~ communicate with and provide Member information.
- ~~s.~~ t. Contractor may use electronic communications for purposes described in ~~Subsection s~~Para. r above of this Sec. 2, Ex. B, Part 3 only if:

- (1) The recipient has requested or approved electronic transmittal;
- (2) The identical information is available in written ~~form,~~ hard copy format upon request;
- (3) The information does not constitute a direct ~~Member~~ notice related to an ~~adverse Action~~Adverse Benefit Determination or any portion of the Grievance, ~~Appeals~~Appeal, Contested Case ~~Hearings~~Hearing 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.

t. Contractor shall ensure that all Contractor's staff who have contact with Potential Members are fully informed of Contractor policies, including Enrollment, Disenrollment, and Fraud, Waste and Abuse, 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.

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: General Information and Education

a. Contractor shall assist Members and Potential Members in understanding the requirements and benefits of Contractor's integrated and ~~coordinated care~~Coordinated Care Services plan. Contractor shall develop draft, and provide written ~~information~~informational 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 and Potential Members about:

- (1) Basic features of managed care;
- (2) Which populations are excluded from ~~enrollment~~Enrollment, subject to mandatory ~~enrollment~~Enrollment, or free to enroll voluntarily in the program;
- (3) Contractor's responsibilities for coordination of Member care~~;~~;
- (4) The ~~services area~~Services Area covered by the Contractor;
- (5) Covered Services and benefits;
- (6) The ~~provider~~Provider directory; ~~and~~
- (7) The requirement for the Contractor to provide adequate access to ~~covered services;~~Covered Services.

~~Written notice must be~~

b. Contractor shall, at least once every Contract Year, provide FBDE Members with written communications regarding opportunities to align Contractor's benefits with its Affiliated MA or DSPN Plans, or both as may be applicable. Contractor shall also communicate regularly with Providers serving FBDE Members about such Member's unique care coordination needs and other health care needs, such as ICC services. ICC services. Contractor shall identify

opportunities to streamline communications to the FBDE Members to improve coordination of Medicare and Medicaid benefits. Such streamlined communications may include the use of integrated Member materials where possible (such as Member handbooks, Provider directories, integrated ID card formats) as permitted by CMS under Medicare regulations

c. All written informational materials, including, without limitation, Member Handbooks, Provider Directories, and educational programs must:

- (1) Without limiting any other requirements under this Para. b, Sec. 4 of this Ex. B, Part 3, meet the requirements set forth in the Member Communications Requirements document located at: <https://www.oregon.gov/oha/OHPB/Pages/CCO2-0-RFA.asp>
 - (a) For each item listed in the Member Communication Requirements document, the column labeled “Text Provided by OHA or Contractor” describes whether OHA or the Contractor is responsible for developing the text. OHA will provide OHA text which may be modified and completed as needed for accuracy, and the Contractor shall develop the text for items identified on the tool as “Text Provided by Contractor.”
- (2) Be in English and translated for Members who speak into all other prevalent non-English languages as provided by OHA in accordance with 42 CFR 438.10 (d)(1), and as defined in 42 CFR 438.10 (e), and notices must include that align with Contractor’s particular Service Area;
- (3) Include language clarifying or otherwise advise Members that that auxiliary aids and oral other interpretation is services are available for all languages and how to access these services to deaf or blind Members, or Members who are both deaf and blind available;
- (4) Be made available through oral interpretation for all languages and how to access these services, in accordance with 42 CFR §438.10 (d)(1), and as defined in 42 CFR §438.10 (c);
- (5) ~~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 submit all member notices and informational material to OHA Materials Coordinator for review and approval no less than 30 days prior to use. Contractor shall furnish to each of its Members a Member handbook that contains all of the information specified in Member Communication Requirements, located on CCO Forms webpage, consistent with the requirements of 42 CFR 438.10(h), 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 annually. 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 Member Communication Requirements, located on CCO Forms webpage. Communicated in a manner that may be easily understood, including those who have limited reading proficiency, and tailored to the~~

backgrounds and special needs of Members and Potential Members within Contractor's Service Area;

- (6) Advise Members and Potential Members that Contractor's written information is available in alternative formats as described above, free of charge, and how to access those formats. Contractor shall advise Members of their right to request and obtain the information described in this section upon Enrollment with Contractor and subsequently no less than at least once every Contract Year; and
- (7) If Contractor may make its required Member information available on Contractor's website. If Contractor so chooses, all such Member information must be: (i) placed in a prominent and readily accessible location on such website, (ii) electronically retained or otherwise archived, and (iii) capable of being printed. Notwithstanding the availability of Member materials on Contractor's website, Contractor must still make all such Member information available in paper form within five (5) days, without charge upon request by a Member or a Member Representative.
- (a) In the context of Member materials, including, without limitation, Provider Directories and Member Handbooks, "readily accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.
- d. Contractor shall develop and provide written informational materials, handbooks and other educational programs as described in OAR 410-141-3280 and OAR 410-141-3300. Such educational programs shall include, without limitation:
- (1) A program that addresses Prevention and Early Intervention of illness and disease; and
- (2) ~~e. Health education shall include:~~ The 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)).
- e. All Member notices, informational, educational materials, and Marketing Materials shall be provided to OHA via Administrative Notice to OHA's Materials Manager for review and approval: (i) prior to use and distribution to Members or any other third-parties, or (ii) by a date certain when so identified in this Contract, and (iii) as may be requested by OHA or its designees from time to time. OHA's Materials Manager shall provide written notice, via Administrative Notice to Contractor's Contract Administrator, of approval or disapproval of such submitted materials within thirty (30) days of OHA receipt of such materials. In the event OHA disapproves of Contractor's informational and educational materials, Contractor shall, in order to remedy the deficiencies in such materials, follow the process set forth in Sec. 5, Ex. D of this Contract. Any and all deficiencies must be corrected within sixty (60) days or, when a deadline for distribution to Members or other third-parties is required under this Contract, such deficiencies must be corrected by the date identified by OHA in its Administrative notice of disapproval or, if no date is identified, with enough time for OHA to review and approve of such materials in order for Contractor to meet the applicable deadline.
- f. ~~d.~~ Upon request of any Member, Contractor shall provide additional information that is Contractor has created that has been pre-approved by OHA and is otherwise 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, and Fraud, Waste and Abuse, 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.~~
- g. Contractor must provide all material changes made to any and all materials previously reviewed and approved by OHA under this Ex. B, Part 3, and any other provision of this Contract, to OHA's Materials Manager, via Administrative Notice, for review and approval. Review and approval or disapproval shall be made in accordance with Para. d of this Sec. 4, Ex. B, Part 3; however, approval or disapproval of material changes will be provided to Contractor within five (5) Business Days, or shorter if required under the circumstances, after receipt by OHA's Materials Manager.
- ~~h. f. Contractor shall provide written notice to affected Members of any Material Change material change in the information described in Subsection e of this section Sec. 4 of Ex. B, Part 3, 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 Notice of any such material changes shall be provided at least thirty (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 thirty (30) day notice requirement. The But in no event shall the material changes take effect, and the applicable materials shall not be distributed or otherwise made available to Members and other third-parties, until after Contractor has received approval of such changes from OHA's Materials Coordinator will review and approve such materials within two Business Days Manager.~~
- ~~g. Contractor shall make its written material available in alternative formats including auxiliary aids, 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, free of charge, 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 Informational Materials for Members and Potential Members: Member Handbook

- ~~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 410-141-3225 through 410-141-3255, and 42 CFR 438.400 through 438.424. 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: Contractor must draft and provide each of its Members, and Potential~~

Members if applicable, with Member Handbook that contains all of the information specified in Member Communication Requirements, located at:
<https://www.oregon.gov/oha/OHPB/Pages/CCO2-0-RFA.asp>

- (1) The information included in the Member Handbook must be consistent with 42 CFR 438.10(g) and OAR 410-14-13280 and the requirements of accessibility set forth in Sec. 4 above of this Ex. B, Part 3.
 - (2) Without limiting any other reporting requirements set forth in this Contract or any guidance documents, Contractor's Member Handbook must advise Members about requesting OHA approved certified and qualified spoken and sign language interpreters, including written interpreting services, and also advise them that such services are provided without charge to Members.
- b. Contractor must provide its Member Handbook to OHA for review and approval: (i) For Contract Year one, no later than November 1, 2019 (ii) upon any material change prior to or after initial review and approval by OHA, (iii) within five (5) Business Days after request by OHA as may be made from time to time, and (iv) annually, with any and all updates, new, or corrected information as needed to reflect the Contractor's internal changes and any regulatory changes on November 1 of the Contract Year preceding the Contract Year in which it will be in effect. Member Handbooks shall be provided to OHA's Materials Manager, via Administrative Notice.
- (1) Compliance with Member Communication Requirements document does not replace the Contractor's obligation to satisfy all the requirements of OAR 410-141-3300 and OAR 41-141-3280 or guarantee OHA's approval of its Member Handbook.
 - (2) In the event OHA disapproves of Contractor's Member Handbook for failing to comply with this Sec. 5 and Sec. 4 of this Ex. B, Part 3 and any other applicable provision of this Contract, Contractor shall, in order to remedy the deficiencies in Contractor's Member Handbook, follow the process set forth in S. 5, Ex. D of this Contract.
- c. Contractor must both mail and otherwise make its OHA approved Member Handbooks within: (i) fourteen (14) days of receiving OHA's initial 834 listing of Member's Enrollment (or re-Enrollment after not being Enrolled for ninety (90) days or more) with the Contractor, (ii) within fourteen (14) days of any other receipt of notice of a Member's Enrollment, and (iii) within the time period required by Medicare if the Enrolled Member is a Fully Dual Eligible Member.
- ~~(1) To the OHA Contract Administration Unit annually no later than January 31st. Contractor may deliver the Member Handbook electronically if the Member has requested or approved electronic transmittal consistent with Sec. 2, Para. s above of this Ex. B, Part 3 of the Contract.~~
 - ~~(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. Contractor must notify all Enrolled Members of each OHA approved revision of its Member Handbook and its location on Contractor's website, and offer to send Members and Potential Members a printed copy promptly after such Members so request.~~
 - ~~(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.~~

- d. Contractor must develop and document a methodology and system for providing copies of translated Member Handbooks to its Members. Such documentation must be provided to OHA or its designees upon request as may be made from time to time.

6. Informational Materials for Members and Potential Members: Provider Directory

- a. In accordance with 43 CFR §438.10(h), Contractor must develop a Provider Directory for its Members which encompasses services delivered under this contract with information necessary to ensure member access to an adequate Provider Network. Contractor may incorporate additional information in its Provider Directory to incorporate priorities from its Community Health Assessment and its Community Health Improvement Plan relating to the delivery of integrated and coordinated physical, Oral Health, Behavioral Health, and Substance Use Disorders treatment services and supports.
- ~~b. Contractor shall provide to all Providers and Subcontractors, at the time they enter into a subcontract, the following Grievance, Notice of Adverse Benefit Determination, Appeal and Contested Case Hearing procedures and timeframes:~~ Contractor shall develop and maintain the Provider Directory such that it meets the requirements set forth in Sec. 4 above of this Ex. B, Part 3 and in OAR 410-141-3300 and any other applicable requirements set forth in this Contract. Contractor's Provider Directory shall identify, at a minimum, its contracted Providers, specialists, pharmacies, Behavioral Health Providers and Hospitals that are located or otherwise serve Contractor's Members in Contractor's Service Area(s).
- c. In keeping with the requirement that Members must be permitted to choose the Member's Provider to the extent possible and appropriate within Contractor's Provider Network. Accordingly, Contractor's Provider Directory shall be developed and written such that it provides Members with the information necessary to make informed choices within Contractor's Provider Network. Contractor's Provider Directory must also include information about Contractor's specialists and Mental and Behavioral Health Providers and such information shall be consistent with and include the same information provided about Contractor's physical health care Providers
- d. In order to be included in Contractor's Provider Directory, Contractor's Providers, whether under contract directly with, or Subcontracted by, Contractor, must have agreed to provide the Covered Services or items to its Medicaid and Fully Dual Eligible Members.
- e. Contractor's Provider Directory shall also include each of the following Provider types listed below in this Para. e, of this Sec. 5, Ex. B, Part 3. Contractor may also include other Provider types who may provide Covered Services to Contractor's Members within Contractor's Service Area(s):
- (1) Physicians, including physical and oral specialists;
 - (2) Hospitals;
 - (3) Pharmacies;
 - (4) Behavioral Health Providers and specialists;
 - (5) Dentists;
 - (6) Dental and Oral Health Providers;
 - (7) NEMT Providers; and
 - (8) LTSS Providers, as appropriate.

- f. For each of the Providers listed in the Provider Directory, Contractor must also include the following information:
- ~~(1) The Member's right to a Contested Case Hearing, how to obtain a hearing and representation rules at a hearing;~~Name and any group affiliation;
 - ~~(2) The Member's right to file Grievances and Appeals and their requirements and timeframes for filing;~~Provider Specialty, as appropriate;
 - ~~(3) The availability of assistance in filing;~~Non-English language spoken and information on cultural and the linguistic capabilities (including Sign Language) offered by the provider or an OHA approved qualified or certified interpreter at the providers office;
 - ~~(4) The toll free numbers to file oral Grievances and Appeals;~~How to request free oral and written language interpreting services (including a sign language interpreter) from a particular Provider;
 - ~~(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 Telephone number;
 - ~~(6) Any State-determined Provider appeal rights to challenge the failure of the organization to cover a service.~~Street address;
 - (7) Whether provider is accepting new CCO members and how to find out;
 - (8) Website, if applicable; and
 - (9) Whether provider's office/service location has accommodations for people with physical disabilities; including offices, exam room(s), restrooms, and equipment.
- g. Contractor's Provider Directory must be updated at least monthly and if material changes so require, more frequently, in accordance with Paras. d and g of Sec. 4 above of this Ex. B, Part 3.
- h. Contractor shall develop and maintain written policies and procedures, criteria, and an ongoing process for managing the information flow, writing, and changing of Provider Directories. Contractor shall provide OHA with such policies, procedures, criteria, and processes as may be requested from time to time.
- i. Contractor shall require its Participating Providers and Subcontractors to adhere to its established policies for Provider Directories and the applicable timeframes for updating the information therein.

7. Grievance and Appeal System

- a. ~~(7) Contractor shall monitor the compliance of its subcontractor and provider network to all~~create and implement a written a Grievance and Appeal System as set forth with specificity in Exhibit I of this Contract, include such documentation, which must comply with the requirements outlined set forth in federal and State law and the provisions of this contractSec. 4 above of this Ex. B, Part 3 and any other applicable requirements set forth in this Contract, in its Member and Provider Handbooks.

~~6. Enrollment and Disenrollment~~

8. a. Enrollment

- a.** ~~1.~~ An individual becomes a Member for purposes of this Contract in accordance with OAR 410-141-3060 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.
- (1)** ~~(a)~~ For persons who are ~~enrolled~~Enrolled on the same day as they are admitted to the Hospital or, for children and adolescents admitted to ~~psychiatric residential treatment services (PRTS)~~Psychiatric Residential Treatment Services, Contractor is responsible for said services.
- (2)** ~~(b)~~ If the person is ~~enrolled~~Enrolled after the first day of a Hospital stay or PRTS, the person will be ~~disenrolled~~Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from Hospital services or the PRTS.
- (3)** ~~(c)~~ For persons who are ~~enrolled~~Enrolled on the same day as they are admitted to ~~the~~ residential treatment services, Contractor is responsible for said services.
- (4)** ~~(d)~~ If the person is ~~enrolled~~Enrolled after the first day of admission to ~~the~~ residential treatment services, the person will be ~~disenrolled~~Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from ~~the~~ residential treatment services.
- b.** ~~2.~~ The provisions of this ~~section~~Sec. 8, Ex. B, Part 3 apply to all Enrollment arrangements as specified in OAR 410-141-3060. OHA will enroll a Member with the CCO selected by the Member. If an eligible Member does not select a CCO, OHA may assign the Member to a CCO selected by OHA in accordance with 42 USC §1396u-2(a)(4)(D). Contractor shall have an open Enrollment period at all times, during which Contractor shall accept, without restriction, all eligible Members in the order in which they apply and are ~~enrolled~~Enrolled with Contractor by OHA, unless Contractor's Enrollment is closed ~~under Paragraph (5)~~as provided for Para. d of this Sec. 8, Ex. B, Part 3.
- c.** ~~3.~~ Contractor shall not discriminate against individuals eligible to ~~enroll~~Enroll, nor Disenroll, on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, 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, gender identity or disability~~such foregoing characteristics or circumstances.
- ~~4.~~ ~~Contractor shall not seek the disenrollment of a member on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity or disability.~~
- d.** ~~5.~~ Enrollment with Contractor may be closed by: (i) OHA upon Administrative Notice to Contractor's Contract Administrator, or (ii) by Contractor notifying the upon Administrative Notice to OHA's designated OHA CCO Coordinator, ~~because if and when~~ 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.
- e.** ~~6.~~ Enrollment with Contractor may be closed by OHA if Contractor fails to maintain an adequate ~~provider network~~Provider Network sufficient to ensure timely ~~member~~Member access to services.
- f.** ~~7.~~ If OHA ~~enrolls~~Enrolls a Member with Contractor in error, OHA will apply the Disenrollment rules in OAR 410-141-3080 and may retroactively ~~disenroll~~Disenroll the Member from

Contractor and enroll the Member with the originally intended ~~contractor~~CCO up to sixty (60) days from the date of the erroneous Enrollment, and the CCO Payment to Contractor will be adjusted accordingly.

- g. ~~8.~~ Contractor shall provide Enrollment validation as described in ~~Exhibit~~Sec 11 below of this Ex. B, Part 3, ~~Section 7(d) of this Contract.~~
- h. ~~9.~~ Contractor shall actively participate with DHS and OHA to transition dual eligible beneficiaries from partial CCO/FFS ~~enrollment~~Enrollment to CCO-A during dual passive ~~enrollment~~Enrollment initiative ~~(DPEI).~~

i.

9. ~~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. All Disenrollment requests and processes shall be made in compliance with the criteria set forth in OAR 410-141-380.

a. ~~(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~~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.

b. ~~(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:

(1) Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or ~~Report fraud online~~

(2) Via on-line portal at https://apps.state.or.us/cfl/OPR_Fraud_Ref/index.cfm?act=evt.subm_web

c. A Member may be Disenrolled from Contractor as follows:

(1) ~~(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:

(a) ~~(i)~~ Without cause:

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

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

iii. ~~(C)~~ A Member may request Disenrollment ~~at least once every~~ during "OHP eligibility renewal," as such term is defined in OAR 410-141-3060, which is typically twelve (12) months ~~after initial Enrollment~~; or

iv. ~~(D)~~ Members who are eligible for both Medicare and Medicaid and Members who are AI/AN American Indian/Alaska Native beneficiaries may change plans or ~~disenroll~~Disenroll to ~~fee~~Fee-for-service Service at any time; or

- v. ~~(E)~~ Upon Automatic Re-~~enrollment~~Enrollment (e.g., a ~~recipient~~Recipient who is automatically re-enrolled after being ~~disenrolled~~Disenrolled, solely because ~~he or she~~such Recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity; or
- vi. ~~(F)~~ Whenever the Member's eligibility is re-determined by OHA.

vii.

(b) ~~(ii)~~ With cause:

i. ~~(A)~~—Members may change plans or ~~disenroll~~Disenroll to ~~fee~~Fee-for-serviceService at any time with cause, as defined in 42 CFR Part 438 and ~~Subsections~~Sub. Paras.~~(Bii)~~—~~(Div)~~ of this ~~section~~SubPara. ~~(1)(b) of this Para. c, Ex. B, Part 3~~; or

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

iii. ~~(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

iv. ~~(D)~~—For other reasons, including but not limited to, poor quality of care, lack of access to services covered under this Contract, an insufficient ~~provider network~~Provider Network, 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:

A. ~~(I)~~—The Member moves out of the Service Area;

B. ~~(II)~~—Services are not provided in the Member's preferred language;

C. ~~(III)~~—Services are not provided in a culturally appropriate manner;

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

E. ~~(V)~~—For Continuity of Care.

(2) ~~(4)~~—OHA may Disenroll a Member upon request by Contractor if Disenrollment is consistent with routine ~~disenrollment~~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~~such Member's OHP Client identification card by ~~another person~~a third-party, altering a prescription, theft or other criminal acts committed in or on any Provider's or Contractor's premises.

(3) ~~(5)~~—OHA may Disenroll a Member upon request by Contractor if Disenrollment is consistent with expedited ~~disenrollment~~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.

(c)

- d. ~~(6)~~ Contractor may not request Disenrollment of a Member solely for reasons related to:
- (1) ~~a.~~ An adverse change in the Member's health status;
 - (2) ~~b.~~ Utilization of health services;
 - (3) ~~e. Diminished~~ physical, intellectual, developmental or mental ~~capacity~~disability;
 - (4) ~~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~~permitted under;
 - (5) Being in the custody of DHS/Child Welfare
 - (6) Prior to receiving any services, including, without limitation, anticipated placement in or referral to a Psychiatric Residential Treatment facility
 - (7) A Member's decision regarding their own medical care with which Contractor disagrees;
or
 - (8) ~~e. Other~~Any other reasons that may be specified in OAR 410-141-3080.
- e. ~~(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.
- f. ~~(8)~~ If OHA ~~disenrolls~~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~~Fee-for-serviceService payment under OHA rules.
- g. ~~(9)~~ If OHA ~~disenrolls~~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 ~~sixty~~(60) days from the date of Disenrollment.
- h. ~~(10)~~ Disenrollment required by adjustments in Service Area or Enrollment is governed by Sec. 14, of Exhibit B, Part 3, Section 64 of this Contract.

10. ~~e.~~ Member Benefit Package Changes

- a. The weekly and monthly ~~enrollment~~Enrollment file (as described in ~~Exhibit~~Sec. 11 below of this Ex. 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.

11. ~~d.~~ Enrollment Reconciliation

- a. ~~(1)~~ Contractor shall reconcile the OHA 834 monthly Enrollment transaction file, sent by OHA to Contractor's Contract Administrator via Administrative Notice, monthly, ~~to~~with 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."
- b. ~~(2)~~ Contractor shall provide, in accordance a report of Contractor's current Member information to OHA's Enrollment Reconciliation Coordinator via Administrative Notice (which must be made

using secure email and which requires Contractor to indicate clearly in the subject line “SECURE”), using the Enrollment Reconciliation Certification Forms, which are available on the CCO Contract Reports Web Site~~Forms Website~~. Contractor’s determination of OHA 834 monthly Enrollment transaction files shall be reported as follows:

- (1) ~~(a)~~ If there are no discrepancies between the OHA 834 monthly Enrollment transaction file with Contractor’s current Member information as reported in Contractor’s HIS, Contractor shall complete, sign, date and ~~submit~~provide the “Enrollment Reconciliation Certification - No Discrepancies” form, to the OHA Enrollment Reconciliation Coordinator within fourteen (14) days of receipt of the OHA 834 monthly Enrollment transaction file, or
 - (2) ~~(b)~~ If there are discrepancies between the OHA 834 monthly Enrollment transaction file with Contractor’s current Member information as reported in Contractor’s HIS, Contractor shall complete, sign, date and ~~submit~~provide the the “Enrollment Reconciliation Certification - Discrepancies Found” form, to the OHA Enrollment Reconciliation Coordinator within fourteen (14) days of receipt of OHA’s monthly Enrollment transaction file.
- c. ~~(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.

12. ~~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 (12). 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.

13. ~~8.~~ Marketing to Potential Members

- a. ~~Contractor shall apply the prohibitions of this paragraph to its agents, delegated entities, Subcontractors, and Subcontractor’s agents. In addition to Contractor’s obligations with respect to Marketing Materials as set forth in Sec. 4 above of this Ex. B, Part 3, Contractor’s Marketing Materials must comply with all the requirements set forth in 42 CFR §438.104 and this Sec. 13, Ex. B, Part 3. Under no circumstances shall Contractor directly or indirectly engage in door to door, emailing, texting, telephone or Cold Call Marketing activities.~~
- 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~~Enrollment.
- c. ~~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~~Marketing Materials shall not contain:
 - (1) 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:~~

(2) Seek to entice Enrollment in conjunction with the sale of or offering of any private insurance

(3) Assert or otherwise state (either in writing or orally) that:

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

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

d. ~~f.~~ Contractor shall comply with the information requirements of 42 CFR 438.10, 438.100 and 438.104 to ensure that prior to enrollment, 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: has sole accountability for producing or distributing Marketing Materials following OHA approval.

~~(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, emailing, texting, 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; After Contractor's Contract Administrator has received approval from OHA of its proposed Marketing Materials, Contractor shall distribute copies of all written Marketing Materials to all DHS and OHA offices within Contractor's Service Area. assertion or statement (whether written or oral) that:~~

~~(2) A clear explanation of OHA's process~~

e. Prior to any use or distribution, Contractor must provide all proposed Marketing Materials to OHA's Materials Manager via Administrative Notice 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.~~

~~9. **Member Communications** by OHA prior to use and distribution. If the Marketing Materials submitted to OHA comply with the requirements under this Sec. 13, Ex. B, Part 3 and any other applicable provisions of the Contract, OHA will provide Contractor's Contract Administrator with Administrative~~

Notice of approval. If, however, the Marketing Materials fail to comply with the requirements under this Sec. 13, Ex. B, Part 3 and any other applicable provisions of the Contract, Contractor shall follow the process set forth in Sec. 5, Exhibit D of this Contract. using or otherwise complying with OHA Materials Submission and Approval Form, which is located on the CCO Contract Forms Website.

f. OHA is in the process of implementing a new electronic system for submitting Marketing Materials and other Contractor materials to OHA. Such system will require the use of a third-party software application which will in turn require Contractor to sign an agreement that obligates Contractor to comply with certain terms and conditions of access which will be in addition to the terms and conditions of this Contract. Contractor understands and agrees that if Contractor desires to use such system, such use is conditioned on Contractor signing the access agreement for the new electronic system.

14. Onboarding of Members Prior to Effective Date of Coverage

- a. By December 10, 2019, OHA will provide Contractor ~~is responsible for preparing a Member handbook to provide informational materials and Member education. Mailing of Member handbooks shall occur within 14 calendar 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.q. and r. of the CCO Contract. Contractor shall notify all existing Members of each revision and its location on Contractor's website, 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 in the Appendix to this Exhibit, with a list of persons who will be Contractor's Members effective as of January 1, 2020.~~
- b. ~~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. OHA 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." Contractor shall compile a Member handbook in each prevalent language for the Members who speak those languages~~ Contractor shall create materials and otherwise complete performance or obtain approval of the items set forth in the table below in this Para. a, Ex. B, Part 3 by the due dates set forth in such table.

	<u>Deliverable</u>	<u>Date Due</u>
<u>(1)</u>	<u>Contractor's Member Transition Plan has OHA approval.</u>	<u>November 1, 2019</u>
<u>(2)</u>	<u>Subcontracts necessary for Contractor's performance of its obligations under the Contract submitted for review and approval.</u>	<u>November 1, 2019</u>
<u>(3)</u>	<u>Written materials to be provided to 1/1/20 Members (including Welcome packets) submitted to OHA for approval.</u>	<u>November 1, 2019</u>
<u>(4)</u>	<u>Subcontracts necessary for Contractor's performance of its obligations under the Contract have OHA approval.</u>	<u>December 1, 2019</u>
<u>(5)</u>	<u>Written materials to be provided to all Members (including Welcome</u>	<u>December 1, 2019</u>

	<u>packets) have OHA approval.</u>	
(6)	<u>Providers necessary for Contractor’s performance of its obligations under the Contract must be properly credentialed and enrolled with Medicaid.</u>	<u>December 15, 2019</u>
(7)	<u>Welcome Packet provided to all Members.</u>	<u>December 15, 2019</u>
(8)	<u>Members who are New Members Enrolled as of January 1, 2020 with current medical needs (including but not limited to currently pre-authorized services and Members receiving Behavioral Health services) contacted with Continuity of Care arrangements so that there is no lapse in coverage or care as of January 1, 2020.</u>	<u>December 20, 2019</u>
(9)	<u>Information regarding Contractor’s plan for transitioning care of Prioritized Populations and those populations identified in OAR 410-141-3061 must be provided to OHA via Administrative Notice</u>	<u>January 1, 2020</u>
(10)	<u>Members who are New Members Enrolled as of January 1, 2020 and a PCP identified</u>	<u>January 5, 2020</u>
(11)	<u>Member Identification cards provided to all Members.</u>	<u>January 5, 2020</u>
(12)	<u>Provider Directory sent to all Members</u>	<u>January 10, 2020</u>
(13)	<u>Both Contractor and Providers have entered into direct contracting or point of service contracts with Providers for New Members with current medical needs to ensure Continuity of Care until at least July 1, 2020 with a plan to transition all Members over to a Participating Provider on or after July 1, 2020.</u>	<u>January 20, 2020</u>

c. ~~If Contractor chooses to provide required Member information electronically, the information must be placed in a prominent and readily accessible location on their website, can be electronically retained and printed. The information must be available in paper form, within 5 days, without charge upon request. The following obligations are subject to the due dates set forth in Para. b above of this Sec. B, Part 3.~~

(1) Subject to the requirements under this Para. b, Sec. 14, Ex. B, Part 3, and as may otherwise be required under other provisions of this Contract, Contractor shall provide all New and Existing Members a Welcome Packet that complies with the requirements set forth in 410-141-3300(7) and 42 CFR §438.10(e). Contractor shall assure that all such materials (i) meet the requirements set forth in Secs. 4, 5, and 6 of this Ex. B, Part 3 and other applicable provisions of this Contract, and (ii) have been provided to and pre-approved in writing by OHA in accordance with Secs. 4, 5, and 6 of this Ex. B, Part 3 and other applicable provisions of this Contract, prior to distribution Members under Sub. Para. (4) below of this Para. b, Sec. 14, Ex. B, Part 3.

- (2) All Existing and New Members, must be Enrolled with Contractor by no later than December 15, 2019. All New Members, and if applicable, Existing Members must receive their Member Identification Cards as required under OAR 410-141-3300 (12).
- (3) For New Members Enrolled with a different CCO under a under a CCO contract on December 1, 2019, Contractor shall cooperate with OHA and such CCO to ensure such New Members are transitioned over to Contractor's plan in accordance Contractor's Plan for Member Transition and with the applicable requirements set forth in Ex. D, Sec.10, relating to the continuation of services, obtaining medical records, Care Coordination, and other requirements as deemed necessary to ensure an orderly transition of the New Member's health care without a disruption to such New Member's health care needs.
- (a) In order to ensure no New Members experience a disruption in services, Contractor shall pay for all Covered Services provided by Non-Participating Providers within our outside Contractor's Service Area until such time such Members can be transitioned to a Participating Provider within Contractor's Service Area without disruption or risk of harm to such Member's health. Contractor shall make arrangements for the provision of such services in accordance with Sub. Para. (13), Para. b above of this Sec. 14, Ex. B, Part 3.
- (4) Contractor shall ensure all of its Participating Providers are enrolled with CMS and properly credentialed prior to the printing of its Provider Directory. All Subcontracts for services, including, without limitation, NEMT Services, Grievance Services, Behavioral Health services, and Pharmacy Benefit Management services, and other Provider services contracts, must be provided to and approved by OHA in accordance with Ex. B, Part 4 prior to such Subcontracts being implemented.
- d. ~~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 OHP.Materials@state.or.us for OHA approval initially and upon revision or upon OHA request. Compliance with the Review Tool does not replace the Contractor's obligation to satisfy~~ Commencing on the Contract Effective Date, Contractor shall comply with all of the requirements of OAR 410-141-3300; it is just a tool for organizing review. following:
- (1) Designate a single point of contact with whom OHA may communicate regarding all Work required to be done with respect to on-boarding all New and Existing Members and all other Work required to be done between the Contract Effective Date through the Coverage Effective Date as is necessary to ensure Contractor is in compliance with all of the terms and conditions of this Contract such that Contractor will be in a position to provide its Members with a services in an orderly and timely manner commencing as of the Coverage Effective Date.
- (2) Have in place adequate staffing to perform all the services required to be performed under this Contract from the Contract Effective Date through the Coverage Effective Date. Such requirement does not preclude or otherwise limit Contractor's obligation to maintain adequate staffing after the Coverage Effective Date and throughout the Term of the Contract.

- (3) Cooperate with OHA and all CCOs in arranging for, as may be necessary, orderly and timely transfer of: (i) New Members receiving services from a different CCO, and (ii) Contractor's existing Members, under a Predecessor CCO Contract to this Contract. Contractor shall also similarly cooperate with OHA and all CCOs to timely transition any and all Members who received services from Contractor under a Predecessor CCO Contract to a new, different CCO or other third-party health plan as provided for in OAR 410-141-3016 and as directed by OHA. Such actions of cooperation and transition shall include, but are not limited to Contractor:
- (b) Forwarding of all records related to Members or their designee as directed by such Member in writing, including those requiring high-needs Care Coordination;
 - (c) Facilitating and scheduling of medically necessary arrangements or appointments for care and services, including arrangements or appointments with Contractor's network Providers for dates of service commencing on or after the Coverage Effective Date; .
 - (d) Identifying chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy; and
 - (e) Continuing to provide Care Coordination until appropriate transfer of care can be arranged for those Members in a course of treatment for which a change of Providers could be harmful.
- (4) Provide OHA with its Certificate of Insurance within five (5) Business Days of the Contract Effective Date. Such Certificate of Insurance shall be made via Administrative Notice.
- (5) Promptly make available any signed Provider agreements requested by OHA.
- (6) Promptly provide OHA with any information OHA requests and deems necessary to ensure that Contractor provides services to its Members in orderly and timely manner as of the Coverage Effective Date.
- (7) Make available (including as applicable requiring its Providers to make available) copies of medical, Behavioral Health, Oral Health and case care management records, files, and any other pertinent information, that relate to Members covered by Contractor under a Predecessor CCO Contract but who will be covered by a new CCO or other third-party health plan as of January 1, 2020. Such records, files and information shall include those maintained or in the custody of a Subcontractor. Contractor shall likewise make arrangements to receive the same from other CCOs for those New Members who will be covered by Contractor under this Contract. Such records shall be in a usable form and shall be provided at no expense to OHA or the Member, using a file format and dates for transfer specified by OHA or the receiving CCO or other third-party health plan. Information required includes but is not limited to:
- (a) Prior Authorizations approved, denied, or in process;
 - (b) Approved Health-Related Services;
 - (c) Program exceptions approved;
 - (d) Current hospitalizations;

- (e) Information on Members in Treatment Plans/plans of care who will require Continuity of Care consideration; and
- (f) Any other information or records deemed necessary by OHA to facilitate the transition of care.

[Remainder of page intentionally left blank]

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~~Continuum of ~~care~~Care that integrates ~~behavioral health, oral health~~Behavioral Health, Oral Health, and physical health interventions seamlessly and holistically, including new ~~member~~Member screenings. 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.

Contractor shall conduct an initial health risk screening of each new Member's needs ~~within 30 days of enrollment or within 10 days when the member is referred or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or in accordance with OAR 410-141-XXXX. Upon initial Enrollment with Contractor, a Member's health risk screening must be completed and documented as quickly as the member's~~Member's health condition requires but in no event more than (i) ninety days of the effective date of Enrollment or within thirty (30) days after the Member has been referred, or the Member is receiving Medicaid Long Term Care or Long Term Services and Supports, or is a member of a priority population for ICC as described in OAR 410-141-3170(2).. Contractor shall maintain documentation on the health risk screening process used for compliance. If the health risk screening requires additional information from the ~~member~~Member, Contractor shall document all attempts to reach the ~~member~~Member by telephone and mail, including subsequent attempts, to demonstrate compliance.

- 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~~Part 160 and 45 CFR Part 164—~~subparts, 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~~Applicable Law.
- b. Contractor shall demonstrate ~~involvement~~participation in ~~integration~~ activities ~~such as, but not limited to~~supporting the Continuum of Care that integrates health services by means of, without limitation:
 - (1) ~~Enhanced~~Facilitating enhanced communication and coordination between and among:
 - (a) Contractor ~~and oral health care Providers, and behavioral health Providers; and Oral Health care Providers, and Behavioral Health Providers;~~Oral Health care Providers, and Behavioral Health Providers;
 - (b) Contractor and MA and SPN Plans and Medicare Providers for FBDE Members;
 - (c) DHS Area Agency on Aging/Aging and People with Disabilities or Office of Developmental Disability Services case managers for, and Providers who provide services to Members receiving Long Term Care or Home and Community Based Services and Member with developmental disabilities who receive services through Community developmental disability programs and organization.
 - (2) ~~Implementation of~~Implementing integrated Prevention, Early Intervention, and wellness activities;
 - (3) ~~Development of~~Developing and implementing infrastructure and support for sharing information, coordinating care, and ~~monitoring~~Monitoring results;
 - (4) ~~Use of~~Using screening tools, treatment standards and guidelines that support integration;

- (5) ~~Support of~~Supporting 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~~MCE to avoid duplication of services, as required by 42 CFR §438.208 (b)(2) and (5).
- d. Contractor shall include the ~~Oregon State Public Health Laboratory (OSPHL)~~ as one of the in-network laboratory ~~providers~~Providers in their networks. Contractor shall reimburse the OSPHL for communicable disease testing ~~laboratory services~~Laboratory Services provided for ~~enrolled members~~Enrolled Members at the rate of the current Medicaid fee schedule for the date of service. The lists of laboratory tests provided by the OSPHL ~~is posted at~~ www.healthoregon.org/labtests. This list (which is subject to change from time to time) is posted at: www.healthoregon.org/labtests

2. Access to Care

Contractor shall provide ~~culturally responsive~~Culturally and ~~linguistically appropriate~~Linguistically Appropriate services and supports; in locations as geographically close as possible; to where Members reside or seek services ~~and, Contractor shall also provide a~~ choice of Providers (including physical health, ~~behavioral health, providers~~Behavioral Health, Providers treating Substance Use Disorders, and ~~oral health~~Oral Health) who are able to provide Culturally and Linguistically Appropriate services within the delivery system network that are, if available, offered in non-traditional settings that are accessible to Families, diverse ~~communities~~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 twenty-four (24) hours a day, seven (7) days a week, when medically appropriate. Contractor shall prioritize timely access to care for Prioritized Populations as set forth in Sec. 10 below of this Ex. B, Part 4. And, as provided for under OAR 410-141-3220, access to care must be provided to certain Members as follows:

- (1) Pregnant women and IV drug users must be provided with an immediate assessment and intake;
- (2) Those with opioid use disorders must be provided with an assessment and intake within seventy-two (72) hours;
- (3) Veterans and their families must be provided with an immediate assessment and intake;
- (4) Those requiring medication assisted treatment must be provided with an assessment and induction no more than seventy-two (72) hours but Contractor must undertake and document efforts to provide care as soon as possible and consider providing ICC Services as applicable under OAR 410-141-3170. With respect to those requiring medication assisted treatment, Contractor must also:
 - (a) Assist such Members in navigating the health care system and utilize Community resources such as Hospitals, Peer Support Specialists, and the like, as needed until assessment and induction can occur;

- (b) Ensure Providers provide interim services daily until assessment and induction can occur and barriers to medication are removed. Such daily services may include utilizing the Community resources identified in Sub. Para. (4)(a) above of this Para. a, Sec. 2, Ex. B, Part 4 or other types of Provider settings. In no event shall Contractor or its Provider require Members to follow a detox protocol as a condition of providing such Members with assessment and induction;
- (c) Provide such Members with an assessment that includes a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and also the potential risks and harm to the Member in light of the presentation and circumstances; and
- (d) Provide no less than two (2) follow up appointments to such Members within 1 week after the assessment and induction.
- (5) For Members with Special Health Care Needs or receiving Long Term Services and Supports determined through an assessment to need a course of treatment or regular care Monitoring, Contractor shall have a mechanism in place to allow Members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. Contractor shall ensure the services supporting Members with ongoing or chronic conditions, or who require Long-Term care and Long-Term Services and Supports, are authorized in a manner that reflects the member's ongoing need for such services and supports and do not create a burden to Members needing medications or services to appropriately care for chronic conditions; and
- (6) Contractor shall have policies and mechanisms for producing, in consultation with the appropriate Providers, including Medicare Providers, an integrated treatment or care plan, or transition of care plan for Members:
 - (a) With Special Health Care Needs,
 - (b) Receiving Long Term Services and Supports, including those Members currently receiving either Medicaid-funded Long Term Care or Long Term Services and Supports from DHS,
 - (c) Who are transitioning from Hospital or Skilled Nursing Facility care,
 - (d) Who are transitioning from institutional or in-patient Behavioral Health care,
 - (e) Who are receiving Home and Community Based Services for Behavioral Health conditions, and
 - (f) FBDE Members enrolled in Contractor's Affiliated MA or DSN Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.
- b.** Report the barriers to access to care for such Members and draft a strategic plan for removing such barriers. Such report and strategic plan must be provided to OHA upon request. Contractor may request technical support from OHA to assist with the efforts required hereunder. Routine ~~oral health~~Oral Health care the Member shall be seen within eight (8) weeks, unless there is a documented special clinical reason which would require longer access time. Pregnant women

shall be provided ~~oral health~~Oral Health care according to the timelines outlined in OAR 410-123-1510.

- 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 ~~Behavioral~~Behavioral Health Practitioner and service site.
- e. Contractor ~~may~~does not ~~have the right to, and shall 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~~any other disability. Contractor shall develop an appropriate Treatment ~~Plan~~Plans with ~~the Members~~such Members and ~~the Family or advocate of the Member~~their Families or advocates to manage such behavior.
- f. Contractor shall implement mechanisms to assess each Member with Special Health Care ~~needs~~Needs and Members receiving Long Term Services and Supports in order to identify any ongoing special conditions that require a course of physical health, ~~behavioral health~~Behavioral Health services, or care management, or all or any combination thereof. The ~~assessment~~Assessment mechanisms must use appropriate health care professionals. ~~(1)~~ For ~~those~~ Members with Special Health Care ~~Needs~~needs and Members receiving Long Term Services and Supports who are determined to need a course of treatment or regular care ~~monitoring, the Intensive Care Coordination Plan (ICCP);~~Monitoring, Contractor must:
- (1) Develop and implement a written ICCP. Each Member's ICCP must be: (i) developed by such Member's Intensive Care Coordinator with Member participation and in consultation with any specialists caring for the Member; (ii) approved by Contractor in a timely manner ~~and,~~ (iii) revised upon ~~assessment~~Assessment of function need or at the request of the Member; Such revisions must be done at least every 3 months for ~~members~~Members receiving ICC services and every ~~twelve (12)~~ months for other ~~members~~Members, if approval is required; ~~and,~~ All ICCPs must be developed in accordance with any applicable OHA quality ~~assessment~~Assessment and performance improvement and Utilization Review standards;
 - (2) ~~Based on the Assessment, Contractor shall assist~~Assist such Members ~~with Special Health Care Needs~~ in gaining direct access to Medically Appropriate care from physical health or ~~behavioral health~~Behavioral Health specialists, or both, for treatment of the Member's condition and identified needs including the assistance available through ~~intensive care coordinators~~Intensive Care Coordinators if appropriate; and
 - (3) Contractor shall implement procedures to share with ~~Members~~such Members's Primary Care Provider the results of its identification and Assessment ~~of any Member with Special Health Care Needs~~ so that those activities are not duplicated. Contractor's procedures shall also require that the ~~Member's assessment information~~Members' Assessments be shared with other ~~prepaid managed care health services organizations~~MCEs serving the ~~Member~~Members. Such coordination and sharing of information must be conducted ~~within federal and State laws, rules, and regulations~~in accordance with Applicable Laws 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 Member with diverse cultural and ethnic backgrounds. Such communication and delivery of Covered Services in compliance with such Acts may also require, without limitation, certified or qualified interpreter services for those Members who have difficulty communicating due to a medical condition, disability, or limited English proficiency, or ~~diverse cultural and ethnic backgrounds, and shall~~where no adult is available to communicate in English, or there is no telephone. Contractor must 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~~ensuring that services provided to Members with disabilities are provided 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~~Para. a, of this ~~section~~Sec. 2, Ex. B, Part 4., Contractor shall develop a methodology for evaluating access to Covered Services as described in ~~Exhibit G~~Sec. 1, Ex. G of this Contract and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3220, OAR 410-141-XXXX, and OAR 410-141-3220.
- (1)** Using the Language Access Report template located on the CCO Contract Forms Website, Contractor shall collect and report language access and interpreter services to OHA. The reported language access data shall be provided to OHA quarterly with monthly detail via Administrative Notice on the third Monday of the months of January, April, July, and October. Reporting required to be made in January shall commence with Contract Year two (2021). Reporting required to be made in April, July, and October shall commence in Contract Year one (2020).
- 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~~3160 and required by 42 CFR 438.208 (b)(1) and (2).
- l.** Contractor shall allow each AI/AN Member 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~~FBDE Members, Contractor shall demonstrate its ability to integrate and provide Medicare and Medicaid benefits to ~~Fully Dual Eligible~~FBDE Members through one or more ~~Medicare Advantage plans that is owned by, affiliated with, or contracted by the~~Affiliated MA Plans or MA Plans with which Contractor ~~has contracted.~~ This shall include, at a minimum, policies and procedures that promote and employ:
 - (1) An integrated approach to ensuring FBDE Members have a PCPCH or PCP.
 - (2) Integrated care plan development.
 - (3) Coordination of care transitions to reduce readmissions.
 - (4) Collaboration to ensure and Monitor Member access to preventive screenings and tests and Behavioral Health services.
 - (5) Coordination of care management services for those requiring ICC services;
 - (6) Coordination of NEMT services to Medicare and Medicaid Covered Services;
 - (7) Work to coordinate HIT to enhance use of HIE, EHR and event notifications as provided for in Ex. J of this Contract;
 - (8) Integrated communications and Member materials as permitted under Medicare; and
 - (9) Use of CMS MA and DSNP Medicare Plan enrollment mechanisms for newly eligible Medicare members.
- p. In the event Contractor is unable to provide local access to care by Providers sufficiently qualified and specialized to treat a Member's condition, it must demonstrate such inability and provide reasonable alternatives to care in accordance with OAR 410-141-3220(7).

3. Delivery System and Provider Capacity

a. Delivery System Capacity

- (1) As specified in 42 CFR 438.206, Contractor shall maintain and ~~monitor~~Monitor a Participating Provider Panel that is supported with written agreements (as specified in Exhibit D, Section ~~1819~~ and this Exhibit B, Part 4, Section ~~4012 to this Contract~~), 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~~OAR 410-141-3220, ORS 414.645, and other Applicable Law, to Members across the age span from child to older adult, including FBDE Members ~~who are Fully Dual Eligible~~.
- (2) Contractor shall ensure ~~members~~Members have access to a ~~provider network~~Provider Network that meets the needs of its ~~members~~Members and ~~potential members~~Potential Members. Contractor shall contract with an appropriate number of ~~providers~~Providers to

ensure ~~member~~Member access to a full continuum of ~~behavioral health~~Behavioral Health, physical, and ~~oral health~~Oral Health services throughout the Contractor's ~~service area~~Service Area. Contractor shall contract with an appropriate number of ~~providers~~Providers to anticipate potential access to care issues in the event of a contracted ~~provider~~Provider leaving the network. In establishing and maintaining the Provider Panel, Contractor shall develop and implement a methodology to establish and ~~monitor network provider~~Monitor Provider Network capacity based on at a minimum, the following factors:

- (a) The anticipated Medicaid Enrollment and anticipated Enrollment of ~~Fully Dual Eligible~~FBDE 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~~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~~Transportation ordinarily used by Members and whether the location provides physical access for Members with disabilities;
 - (f) Data collected from Contractor's ~~grievance~~Grievance and ~~appeal system~~Appeal System;
 - (g) Data collected from Contractor's ~~monitoring~~Monitoring of ~~member~~Member wait time to appointment;
 - (h) Any deficiencies in network adequacy or access to services identified through the course of self-audit, reviews conducted by OHA's contracted EQRO, ~~monitoring~~Monitoring conducted by OHA, or audits conducted by any other ~~state~~State or federal agency;
 - (i) 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 414.645;
 - (j) The number of Providers who are not accepting new Members; and
 - (k) The number of ~~members~~Members assigned to PCPCHs.
- (3) As set forth in additional detail in Sec. 4 below of this Ex. B, Part 4 and Ex. G of this Contract, Contractor shall report on its Delivery System Network (~~DSN~~), identifying all individual ~~providers~~Providers and facilities that hold written agreements with Contractor to provide services to its ~~members~~Members, including an appropriate range of preventive, primary care, ~~behavioral health, oral health~~Behavioral Health, Oral Health, and other specialty services, sufficient in number, mix and geographic distribution to meet Member needs, ~~using Exhibit G.~~
- (4) Contractor shall allow each Member to choose a Provider within the Provider Network to the extent possible and appropriate.

- (5) Contractor shall coordinate its service delivery system with organized planning efforts carried out by the local mental health authority in its Service Area.
- (6) Contractor shall contract with a sufficient number of Substance Use Disorders residential treatment facilities to ensure timely access to Covered Services.
- (7) Contractor shall ensure that its Participating Providers contract with facilities that ~~can~~ meet cultural responsiveness and linguistic appropriateness, the diverse needs of its Members, including, without limitation, adolescents, parents with dependent children, pregnant women, IV drug users and ~~Members~~those with medication assisted therapy needs.

4. Provider Workforce Development

- a. In addition to the data collection and reporting requirements identified in Sub. Para. (3) above of Para. a, Sec. 3 above of this Ex. B, Part 4, Contractor must also annually collect and report on data regarding the Provider demographics within Contractor's Service Area. Using such data, Contractor must also develop and implement strategies to develop a Provider workforce that enables Contractor to provide, within its Service Area, needed services in a manner that is Culturally Responsive, linguistically appropriate and Trauma Informed and that gives attention to marginalized populations.
- b. In order to comply with such obligations, Contractor's annual Workforce report must:
 - (1) ~~a. Contractor shall provide a report to OHA at the beginning of CY 2020 and each contract year thereafter, describing~~Include a description of the demographics of: (i) the members~~Members in the Contractor's network,~~Contractor's Service Area, (ii) the physical, behavioral, and Oral Health needs within Contractor's Service Area, and (iii) its current oral, behavioral, and physical health provider~~Provider~~ workforce in Contractor's ~~region, and the plan to meet member~~Service Area;
 - (2) Describe Contractor's plan for meeting its Members's oral, behavioral, and physical health care needs;
 - (3) ~~b. Contractor shall utilize~~Utilize data provided by OHA (as such data is required to be provided under OAR 410-141-3200(e)) and from Contractor's relevant reports on workforce capacity and diversity to inform Contractor's workforce development strategies;
 - (4) ~~c. Contractor shall dedicate a portion~~As part of its workforce development ~~efforts and investments towards~~plan, Contractor shall address the strategies it will implement to develop and invest in Traditional Health Workers ~~based on~~so that such Workers will align with the needs of Contractor's ~~members~~Members and overall ~~provider network.~~Provider Network;
 - (5) As part of its workforce development plan, address the strategies Contractor will undertake to work with local communities, local and State educational resources using OHA-identified best practices to develop an action plan to ensure its Workforce is prepared to provide the physical, Behavioral, and Oral Health services to the Members within Contractor's Service Area in a manner that is Culturally Responsive, linguistically appropriate and Trauma Informed;
 - (6) ~~d. Contractor shall demonstrate~~Provide evidence that either (i) 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~~(ii) no or very few Indian Health Care Providers ~~or that none exist in~~are offering services or otherwise located within Contractor's Service Area~~;~~;

- ~~(7) e. Contractor shall promote~~Promote the delivery of services in a ~~culturally responsive~~Culturally Responsive manner to Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds~~;~~;
- ~~(8) f. Contractor shall identify~~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~~;~~; and
- ~~(9) g. Contractor shall require and provide training or ensure training is provided on implicit bias for all of Contractor's staff and provider network as described in Exhibit N.~~Provide and require employee and Provider Network attendance at trainings on implicit bias as set forth in Para. d, Sec.10, Ex. K to this Contract.
- c. In accordance with the criteria set forth in Paras. a. and b. above of this Sec. 4, Ex. B, Part 4, Contractor shall annually update and revise its Workforce report and the plan set forth therein.
- d. Contractor shall provide a Workforce report to OHA annually via Administrative Notice. For Contract Year One, such report must be provided to OHA between January 1 and January 31, 2020. Contractor's Workforce.
- e. For Contract Years two through five, such report must be provided to OHA on January 31, all of which must include assessments of the progress and effectiveness of its workplan.
- f. OHA shall annually review Contractor's Workforce report for compliance with this Sec. 4, Ex. B, Part 4. In the event OHA determines Contractor's Workforce report fails to comply with such criteria, Contractor shall follow the process set forth in Sec. 5, Ex. D.
- g. h.—If Contractor is unable to provide any necessary Covered Services which are culturally responsiveCulturally Responsive and linguistically and Medically Appropriate to a particular Member within its Provider ~~Panel~~Network, Contractor shall adequately and timely cover these services out of network for the Member, for as long as Contractor is unable to provide ~~them~~such services. 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.

5. Provider Selection

Contractor shall establish written policies and procedures that comply with credentialing and re-credentialing requirements outlined in OAR 410-141-3120, the requirements specified in 42 CFR §438.214, which include selection and retention of Providers, and nondiscrimination provisions.

- a. In establishing and maintaining the network, Contractor shall:
- ~~a. — Complete the DSN Provider Report as required in Exhibit G and submit to the OHA Contract Administration Unit no later than 30 days following the end of each quarter. Contractor shall update its DSN Provider Report at any time there has been a change in Contractor's operations that would impact provider capacity and the availability of 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;~~

- (1) Complete and provide OHA with DSN Provider Reports as set forth in Exhibit G to this Contract;
- (2) ~~b.~~ Use Provider selection policies and procedures, in accordance with 42 CFR §438.12 and 42 CFR §438.214, that do not discriminate against Providers that serve high-risk populations or ~~who~~ specialize in conditions that require costly treatment. ~~;~~
- (3) 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, and include with such notice Contractor's Provider selection policy;
- (4) ~~e.~~ Provide a dispute resolution process, including the use of an independent third party arbitrator, for a Provider's refusal to contract with Contractor or for the termination, or non-renewal of a Provider's contract with Contractor, pursuant to OAR 410-141-3269.
- ~~d.~~ ~~Provide a written justification for Contractor's refusal to contract with a Provider or groups of Providers, and make Contractor's provider selection policy available to the Provider when Contractor declines to contract;~~
- (5) ~~e.~~ AssureEnsure that all Traditional Health Workers, ~~who~~whether they are ~~employed by Subcontractors or Contractor or subcontractors, have met~~employees, undergo and meet the requirements for, and pass the background ~~checks~~check required of for Traditional Health Workers, as described in OAR 410-180-0326;
- (6) ~~f.~~ Terminate its contract or Subcontract with a ~~provider~~Provider immediately upon ~~notification~~receipt of Legal Notice from the State that a ~~provider may not be~~Provider is precluded from being enrolled as a Medicaid Provider; and
- ~~g.~~ Apply the same credentialing and ~~enrollment~~Enrollment criteria required of ~~providers~~Providers enrolling with OHA as Fee for Service ~~providers~~Providers.
- b. In accordance with 42 CFR §438.602(b)(1) OHA will screen and enroll ~~providers~~Providers and revalidate all of Contractor's ~~providers~~Providers as Medicaid ~~providers~~Providers. Contractor may execute ~~provider~~provisional Provider contracts pending the outcome of screening and ~~enrollment~~Enrollment with OHA, for no longer than one hundred and twenty (120) days, and Contractor shall terminate the contract immediately if notified by OHA that the Provider ~~cannot be~~is precluded from being enrolled ~~as a Medicaid Provider. Notwithstanding the foregoing,~~ Contractor may not execute provisional ~~provider~~Provider contracts with moderate or high-risk ~~providers~~Providers who are required to undergo fingerprint-based background checks until the ~~provider~~Provider has been approved for ~~enrollment~~Enrollment by OHA.

6. 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 including acute, primary, dental, behavioral, ~~substance use disorder~~Substance Use Disorder Providers 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 of this Contract, except as provided in ~~Subsection~~Para. b, of this ~~Section~~Sec. 6, Ex. B, Part 4. These procedures shall also include

collecting proof of professional liability insurance, whether by insurance or a program of self-insurance.

- b. When credentialing Providers or ~~provider~~Provider types designated by CMS as “moderate” or “high-risk,” Contractor shall ~~provide to OHA,~~ at the time of enrollment, provide to OHA with documentation, via Administrative Notice, that demonstrates the Provider has undergone a fingerprint-based background check and site visit within the previous 5 years. For a Provider ~~that who~~ is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, this will be deemed to satisfy the requirement for OHA ~~provider enrollment~~Provider Enrollment.
- c. Contractors shall ensure Telemedicine credentialing requirements are consistent with OAR 410-130-0610~~(3)~~.
- d. 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 in the DSN Provider Report required under Ex. G of this Contract,~~ the date ~~that the person~~such Provider’s education, experience, competence, and supervision are adequate to permit ~~the person to perform his or her~~performance of such Providers 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 such Participating Providers must either:
- (a) ~~Participating Providers must meet~~Meet the definitions for ~~QMHA (qualified mental health associate) or QMHP (qualified mental health professional) as described in Exhibit A, Definitions and~~Qualified Mental Health Associate or Qualified Mental Health Professional and must not be permitted to provide services ~~under~~without the supervision of a ~~LMP (licensed medical practitioner) as defined in Exhibit A, Definitions~~Licensed Medical Practitioner; or
- (b) ~~For Participating Providers~~If not meeting either the definitions of a QMHP or QMHA definition, Contractor shall document and certify that have the person’s education, experience, competence, ~~and supervision are adequate necessary~~ to permit perform the ~~person~~specified assigned duties and Contractor must document and report to OHA in its DSN Provider Report: (i) the education, experience and competence of such Participating Provider, and (ii) that such Participating Provider will not be permitted to perform ~~his or her~~the specific assigned duties without the supervision of a Licensed Medical Practitioner.
- (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.
- e. 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 in accordance with Sec. 5, Para. a, Sub. Para. (3) above of this Ex. B, Part 4. 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.
- f. 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~~in the ~~OHA-DSN Provider Report required to be made in accordance with, Ex. G of this Contract.~~ Contractor may not refer Members to or use Providers who do not have a valid license or certification required by ~~state or federal law~~Applicable Law. If Contractor knows or has reason to know that a Provider's license or certification is expired ~~or, has~~ not been renewed, or is subject to ~~licensing or certification~~ sanction or administrative action, ~~the~~ Contractor must immediately ~~notify~~provide ~~OHA's Provider Services Unit~~ with Administrative Notice of such circumstances.
- g. Contractor ~~may~~shall 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~~shall not employ or contract with ~~providers~~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~~shall not accept billings for services provided to Members ~~provided~~ after the date of the Provider's exclusion, conviction, or Provider 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~~State laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), ~~the~~ Contractor must immediately ~~notify OHA's Provider Services Unit~~provide such information to OHA via Administrative Notice.
- h. Contractor ~~may~~shall not pay for ~~any~~any item or service that would otherwise be a Covered Service (other than an emergency item or service, not including items or services furnished in an emergency room of a ~~hospital~~) in Hospital) under any of the following circumstances:
- (1) ~~Furnished under the plan~~When furnished by any individual or entity during any period when the individual or entity is excluded from participation under title V, Sec. 504, including, title XVIII, XIX, 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.

- (2) 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~~Payment, as stated in section 1903(i)(2)(C) of the Social Security Act.
 - (3) 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.
 - (4) 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 Contractor must only use~~ registered National Provider Identifiers (NPIs) and taxonomy codes reported to ~~the~~OHA in ~~the~~its DSN Provider Capacity Report ~~may be used~~(as required under Ex. G of this Contract) for purposes of ~~encounter data~~Encounter Data submission, prior to submitting ~~encounter data~~Encounter Data in connection with services by the Provider.
 - j. Contractor shall require each Physician and every other qualified Provider to have a unique ~~provider~~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 credentialing of Providers and the delivery of Covered Services, applicable administrative rules, and ~~the~~Contractor's administrative policies as set forth in Sec. 11, para. b, Sub. (8) of Ex. B, Part 9.

7. Patient Centered Primary Care Homes (~~PCPCH~~)

- a. Contractor shall include in its network, to the greatest extent possible, Patient-Centered Primary Care Homes as identified by OHA. Contractor shall develop and assist in advancing Providers along the spectrum of the PCPCH model (from Tier 1 to Tier 5). Contractor shall assist Providers within its delivery system to establish PCPCHs.
- b. In addition to Provider reporting requirements ~~described in OARs~~required under this Contract and Applicable Law, Contractor shall provide OHA with a quarterly report ~~to OHA Contract Administration Unit~~, no later than thirty (30) days following the end of each quarter, ~~to include that lists~~ all Members that who are assigned to a PCPCH Provider ~~listed out by tier 1, 2, 3, 4 or 5.~~ Such report shall be provided to OHA via Administrative Notice. Contractor shall coordinate with each PCPCH Provider in developing these lists ~~and the report shall list all such Members by tier levels 1, 2, 3, 4, or 5.~~
- c. Contractor shall require its Providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.
- d. Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of Health System Transformation.
- e. ~~In this connection,~~ Contractor shall contract with a network of PCPCHs recognized under Oregon's standards (OAR 409-055-0000 to 0090). Contractor shall draft and provide OHA with the plans set forth below in Sub. Paras. (1) and (2) of this Para. e, Sec. 7 of this Ex. B, Part 4. Such plans shall be provided to OHA via Administrative Notice by no later than February 15 of each Contract Year.:

- (1) A work plan for increasing the number of ~~enrollees~~Members served by certified PCPCHs over the first five years of operation, including targets and ~~benchmarks~~Benchmarks; and
 - (2) 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~~Benchmarks.
- f. Contractor shall ensure that Members of all ~~communities~~Communities in its Service Area receive ~~integrated, culturally responsive and linguistically appropriate~~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. ~~(1) —~~
In order to ensure Members have the ability to utilize such model of care, Contractor shall encouragemust:
- (1) 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.;
 - (2) ~~Contractor shall negotiate~~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 Section 4712(b)(2) of the Balanced Budget Act of 1997;
 - (3) ~~Contractor shall offer~~Offer contracts to all Medicaid eligible IHCPs in ~~the area they serve~~its Service Area and provide access to specialty and primary care within their networks to CCO-enrolled Indian Health Services beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted ~~provider~~Provider within the Contractor's network.;
 - (4) ~~The Contractor must adopt~~Adopt the CMS “Model Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)” (~~Model IHCP Addendum in CCO Forms webpage~~) or an addendum agreed upon in writing by the Contractor and every tribe and ~~Indian Health Care Provider~~ (IHCP) in ~~the~~ Contractor's ~~region~~Service Area. IHCPs may agree to include additional provisions in the Model IHCP Addendum. The Model IHCP Addendum is located on CCO Forms Website; and
 - (5) Contractors and IHCPs interested in entering into a contract ~~will~~must reach an agreement on the terms of the contract within six months of expression of interest or initial discussion between ~~the CCO~~Contractor and IHCP, unless an extension is agreed upon by both parties.
 - (a) If the Contractor and IHCP do not reach an agreement on the terms of the contract within six months, the IHCP may request the assistance of a ~~state~~State representative to assist with negotiation of the contract.
 - (b) The ~~state~~State will use an informal process to facilitate an in-person meeting with the Contractor and IHCP to assist with the resolution of issues.
 - (c) If an informal process does not lead to an agreement, the Contractor and IHCP will use the existing dispute resolution process described in OAR 410-141-3269. The informal process shall be used as guidance and will not be binding.

- (d) Upon agreement of terms ~~as addresses in (1)(b)~~, Contractor and IHCP must finalize and approve the contract within ninety (90) days of reaching an agreement.

8. Care Coordination

Contractor shall provide ~~following all of the~~ elements of ~~care coordination~~Care Coordination as set for the below in this Sec. 8, Ex. B, Part 4. Accordingly, Contractor shall do all of the following:

- a. ~~Contractor shall support~~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~~effectively plan, communicate, and implement transition and care planning and follow-up;
- b. ~~Contractor shall~~Work with Providers, and for FBDE Members, work with Affiliated MA and DSN Plan or Medicare Providers, to develop the partnerships necessary to allow for access to, and coordination with, social and support services, including culturally specific ~~community~~Community-based organizations, ~~community-based~~Community-Based mental health services, DHS Medicaid-funded ~~long term care services~~Long Term Care and Home and Community Based Services, DHS Office of Developmental Disability Services, Community based developmental disability Providers and organizations, and mental health crisis management services;
- c. ~~Contractor shall develop culturally responsive and linguistically appropriate~~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~~Care Coordination;
- d. ~~Contractor shall coordinate~~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~~Document and submit annually no later than June 30th an update of coordination activities ~~through Memoranda of Understanding (that have been agreed to in a MOU)~~; or ~~subcontractual arrangement(s) in Subcontract~~ 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/SENIORS-DISABILITIES/LTC/Pages/HST-APD-CCO.aspx>
 - (1) MOUs ~~will be reviewed~~are subject to review and approval by DHS-APD and OHA ~~and feedback will be given,~~ which shall be provided via Administrative Notice to Contractor's Contract Administrator. In the event OHA disapproves of the MOU, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.
- f. Contractor shall coordinate with residential ~~behavioral health services~~Behavioral Health service 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 the Oregon State Hospital, ~~state~~other State institutions, and other mental health ~~hospital~~Hospital settings, to facilitate Member transition into the most appropriate, independent, and integrated ~~community~~Community-based settings.

- h. Contractor shall use ~~evidence-based~~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, Special Health Care Needs, or other chronic conditions, who receive home and ~~community-based~~Community-Based services under ~~the State's~~Section 1915(i)~~State, the States~~ Plan Amendment, or any Long Term Services and Supports through DHS as follows:
- (1) 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;
 - (2) Individual care plans: Contractor shall use individualized care plans to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with ~~intensive care coordination~~ICC 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; ~~and~~
 - (3) Communication: Contractor shall encourage and work with their Providers to develop the tools and skills necessary to communicate in a ~~culturally responsive and linguistically appropriate~~Culturally and Linguistically Appropriate fashion and to integrate the use of HIE and event notification.

9. Care Integration

- a. Contractor shall ~~ensure~~provide the ~~provision of the following~~ elements of ~~Care Integration~~integrated care as set forth in this Para. a, Sec. 9, Ex. B, Part 4. Accordingly, Contractor must:
- (1) ~~Mental Health and Substance Use Disorders Treatment:~~Integrate Outpatient ~~behavioral health~~Behavioral Health treatment ~~shall be integrated into~~with a person-centered care delivery system ~~and~~which must be coordinated with physical health care services by Contractor and by Contractor's transformed health system;
 - (2) ~~Oral Health: Contractor shall provide~~Provide adequate and appropriate access to dental ~~providers~~Providers for ~~oral health~~Oral Health services.
 - (3) ~~Hospital and Specialty Services: Contractor shall provide~~Provide adequate, timely and appropriate access to specialty and Hospital services. Contractor's service agreements with specialty and Hospital Providers ~~shall~~must: (i) address the coordinating role of patient-centered primary care; ~~shall~~(ii) specify processes for requesting Hospital admission or specialty services; and ~~shall~~(iii) establish performance expectations for communication and medical records sharing for specialty treatments; ~~(x)~~ (y) at the time of Hospital admission or (y) at the time of Hospital discharge; ~~for the purpose of facilitating~~ after-Hospital follow up appointments and care. Contractor ~~shall demonstrate how~~ is responsible for holding Hospitals and specialty service ~~providers are~~Providers accountable for achieving successful transitions of care. Contractor ~~shall ensure that's~~ primary care teams ~~transition~~are responsible for transitioning Members out of Hospital settings into the most appropriate, independent, and integrated care settings, including

home and ~~community-based~~Community-Based as well as Hospice and other palliative care settings.

~~(4)~~ Engage in collaborative care coordination for FBDE Members with Contractor's Affiliated MA or DSN Plans, or both as applicable.

b. Contractor ~~shall ensure~~is responsible for documenting, and maintaining such documentation, that Members have been provided with all of the ~~following~~ features of the delivery system:

~~(4)~~ Each as set forth below. Accordingly, Contractor must have documentation demonstrating that, as applicable, each Member has:

~~(1)~~ Had access to a consistent and stable relationship with a primary care team that is responsible for comprehensive care management and transitions.;

~~(2)~~ The Had their 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 receiveReceived comprehensive ~~transitional care~~Transitional Care, including appropriate follow-up, when ~~entering and leaving an acute~~such Member entered and left and Acute care facility or a long term care setting.;

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

~~(5)~~ Members haveHad access to advocates such as Traditional Health Workers who may be part of the Member's primary care team.;

~~(6)~~ Members areBeen 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.;

~~(7)~~ Received health risk screenings and, as appropriate, assessed for Long Term Services and Supports

10. Delivery System Dependencies

a. **Intensive Care Coordination for Prioritized Populations and Members with Special Health Members Care Needs**

~~(1)~~ Contractor shall prioritize working with Members who ~~have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders~~are eligible for ICC services and communities experiencing health disparities (as identified in the ~~community health assessment~~Community Health Assessment). Contractor shall actively engage ~~those~~such 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.

~~(a)~~ Children and adolescents in foster care or under the custody of DHS are deemed a Prioritized Population by OHA. Therefore, Contactor must prioritize Intensive Care Coordination of physical, Behavioral Health, and Oral Health services, regardless of whether the services are Covered or Non-Covered Services, utilizing Contractor's Participating Providers or, if none are available, Non-Participating Providers, to children and adolescents placed by DHS outside of Contractor's

Service Area for the purpose of participating in a Behavior Rehabilitation Services Program that meets the criteria set forth in OAR 410-170-0090(1) –(5) or for any other reason that DHS deems necessary.

- (2) Contractor shall provide ~~Intensive Care Coordination 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.~~ ICC services as set forth in Sec. 8, Para. a., of Ex. B, Part 2 of this Contract.
- (3) Contractor shall implement procedures to share with Participating Providers, in order to avoid the duplication of services and activities, the results of its identification and Assessment of any Member identified as ~~aged, blind, disabled (i) having Special Health Care Needs, including mental illness or substance abuse disorders) or older adults, (ii) being blind, deaf, hard or hearing, or have other disabilities, (iii) having complex medical health needs~~ with Participating Providers serving the Member so that those activities need not be duplicated, high health care needs, multiple chronic conditions, Behavioral Health issues, including SUD, (iii) receiving Medicaid funded Long-Term Care or Long Term Services and Supports receiving Home and Community Based Services consistent with 42 CFR §438.208. .
- (4) Contractor shall create procedures and share information (e.g. via HIE or regularly scheduled interdisciplinary or multidisciplinary care conferences) for the purposes permitted under ORS 414.679 ~~in compliance with the~~ and subject to the information security and confidentiality requirements set forth therein as well as any other confidentiality and information security requirements of this Contract and other Applicable Laws.
- (5) ~~(4)~~ Contractor shall establish a system supported by written policies and procedures, for identifying, assessing and producing a Treatment Plan for each Member identified as having a special healthcare need, including a standing ~~referral~~ Referral process for direct access to specialists. Contractor shall ensure that each Treatment Plan:
- (b) ~~(a)~~ Is developed by the Member's designated PCP or other Practitioner with the Member's participation;
- (c) ~~(b)~~ Includes consultation with any specialist caring for the Member;
- (d) ~~(e)~~ Is approved by ~~the~~ Contractor in a timely manner, if ~~this~~ such approval is required; and
- (e) ~~(d)~~ Accords with any applicable State quality assurance and Utilization Review standards.

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

Contractor shall promote communication and coordination with ~~state~~ State and local government agencies and culturally diverse ~~community~~ Community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical for the development and operation of an effective delivery system. Contractor shall consult and collaborate with its Providers to: (i) maximize Provider awareness of available resources to ensure the health of Contractor's diverse Members' health, and ~~to~~ (ii) assist Providers

in referring Members to the appropriate Providers or organizations. Contractor shall ensure that the assistance provided regarding ~~referrals~~Referrals to State and local governments and ~~community~~Community social and support services organizations takes into account the ~~referral~~Referral and service delivery factors identified in the Community Health Assessment and Community Improvement Plan.

c. Cooperation with Dental Care Providers

Contractor shall coordinate preauthorization and related services between Physical and Dental Care Providers to ensure the provision of Dental Services when such services are to be performed in an outpatient Hospital or ~~ASC~~, in ~~eases in which the~~an outpatient Hospital or ASC, when a Member's age, disability, or medical condition ~~of the Member~~ necessitates providing services in ~~an outpatient Hospital or ASC~~such facilities.

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

Contractor shall arrange to provide medication, as covered under Contractor's Global Budget, to Members located in nursing or residential ~~facility~~facilities, and in group or foster ~~home~~residentshomes. All medications shall be provided in a format that is reasonable for each facility, including the facility's manner of delivery, dosage, and packaging requirements and Oregon law as permitted under State and federal law. Contractor shall ensure Members in Nursing Facilities, Foster Care, Group Homes and other similar residential settings have access to and are provided with all medically necessary services provided by Contractor under this Contract, including, without limitation, oral care and Behavioral Health assessments, by collaborating and coordinating with such facilities.

11. Evidence-Based Clinical Practice Guidelines

Contractor shall adopt, disseminate, and apply practice guidelines, as 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 that comply with the requirements set forth in 42 CFR §438.236 (b) in consultation with Contractor's Participating Providers ~~and shall~~. Contractor must review and update ~~them~~such guidelines 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.~~

~~12. Health Promotion and Prevention~~

~~Contractor shall provide evidence-based care in a culturally responsive 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 responsive 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.~~

- ~~e. — 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 (4rd edition) (2017) 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 the 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 responsive and linguistically diverse communities and specify the actions Contractor will take to reduce or eliminate health disparities.~~
- ~~i. — Disseminate culturally responsive 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.~~

12. ~~13.~~ Subcontract Requirements

~~The Contractor’s Subcontracts, including those entered into with Providers, must comply with the requirements of set forth Sec. 12 of Ex. B, Part 4. However, nothing in this section Sec. 12 precludes 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. Subcontracts provided that such additional terms and conditions do not conflict or otherwise amend with the requirements set forth herein and as otherwise required under this Contract. In no event shall Contractor delegate or otherwise assign to third parties the responsibility for performing any Work required under this Contract without first entering into a Subcontract that complies with the terms and conditions of this Contract. In all such instances, Contractor shall ensure that, at a minimum, include all of the following standards are included, terms, and conditions in all of its Subcontracts:~~

a. General Standards

- (1) To the extent Contractor Subcontracts any services or obligations to a Subcontractor, Subcontractor must perform the services and meet the obligations and terms and conditions as if the Subcontractor is the Contractor.
- (2) Contractor shall ensure that all subcontracts Subcontracts: (i) are in writing, (ii) specify the subcontracted Subcontracted Work and reporting responsibilities, meet (iii) are in compliance with the requirements described below in this Sec. 12, Ex. B, Part 4 and any other requirement as described throughout requirements identified in this Contract, and

- ~~(iv)~~ incorporate ~~portions~~the applicable provisions of this Contract, ~~as applicable~~, based on the scope of Work ~~to be~~ subcontracted such that the provisions of the Subcontract are the same as or substantively similar to the applicable provisions of this Contract.
- ~~(3)~~ Contractor must evaluate ~~the~~and document all prospective ~~Subcontractor~~Subcontractors's readiness and ability to perform the scope of ~~work outlined~~Work set forth in the ~~written agreement~~applicable Subcontract prior to the effective date of the ~~contract~~. ~~Copies of the evaluation shall be provided to OHA any time~~Subcontract. OHA shall have the right to ~~request, and~~ Contractor ~~enters into a new Subcontractor agreement~~shall provide within five (5) days after request by OHA, all readiness review evaluations.
- ~~(4)~~ ~~(2)~~ Contractor shall ensure that all Subcontractors are screened for exclusion from participation in federal programs, ~~and~~. In the event a Subcontractor is so excluded, Contractor is prohibited from contracting with any subcontracting to such Subcontractor who is an excluded entity any Work or obligations required to be performed under this Contract.
- ~~(5)~~ ~~(3)~~ Contractor shall ensure that all Subcontractors and their employees undergo a criminal background check prior to starting any ~~work~~Work identified in this Contract.
- ~~(6)~~ ~~(4) Some activities in this agreement may not be subcontracted~~Contractor shall not have the right to Subcontract certain obligations and ~~must~~Work required to be performed ~~by the Contractor~~under in this Contract. Work, activities, and other obligations that ~~may~~Contractor shall not be subcontracted is Subcontract are identified ~~as such~~ throughout this ~~contract~~Contract. Subject to the provisions of this ~~section~~Section 12, Ex. B, Part 4, Contractor may ~~subcontract any of the~~Subcontract obligations and Work required to be performed under this Contract that is not expressly identified as an exclusion. ~~No~~ In accordance with 42 CFR §438.230(b)(1), 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~~ A breach of this Contract by a Subcontractor shall be deemed a breach of Contractor and Contractor shall be liable for such Subcontractor breach. The imposition of any and all Corrective Action, Sanctions, ~~recovery~~ Recoupment, Withholding and other recovered amounts and enforcement actions ~~are~~against any Subcontract is solely the responsibility of ~~the~~ Contractor. Contractor retains all legal responsibility and ~~may~~shall not delegate have the right to Subcontract the responsibility for ~~monitoring~~Monitoring and oversight of ~~subcontracted~~Subcontracted activities. ~~Contractor retains responsibility for adhering to and otherwise fully complying with all terms and conditions of this contract.~~
- ~~(7)~~ ~~(5)~~ Contractor shall provide to OHA via Administrative Notice, a Subcontractor Assignment Report in which Contractor shall summarize in list of any form all activities ~~outlined in~~required to be performed under this ~~contract~~Contract that have been subcontracted ~~using the Subcontractors and Delegated Entities Report template.~~
- ~~(6)~~ ~~The report should identify any activities Contractor has agreed to perform under this to a Subcontractor. The Subcontractor Assignment Report must be provided to OHA by no later than January 31 of each Contract that Year and within thirty (30) days after there has been subcontracted or delegated, and include information related to the subcontracted work including any change in a Subcontractor. The Subcontractor Assignment Report shall also include all of the following:~~

- (a) The legal name of the Subcontractor;
 - (b) The scope of ~~work~~Work being subcontracted;
 - (c) Copies of ownership disclosure form, if applicable;
 - ~~(d) Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230;~~
 - ~~(e) Any ownership stake between Contractor and the Subcontractor;~~ and
- ~~(7) Contractor shall provide this information in the Subcontractor and Delegated Entity Report no later than January 31st of each year, and shall notify OHA within 30 days any time there has been a change in subcontractor.~~
- (e) An attestation that Contractor (i) conducted a readiness review of the Subcontractor, (ii) confirmed that the Subcontractor was and is not an excluded from participation in federal program, (iii) confirmed all Subcontractor employees are subject to criminal background checks, and (iv) that the written Subcontract entered into with the Subcontractor meets all of the requirements set forth in this Ex. B, Part 4 and other applicable provisions of this Contract
- (8) ~~The~~In addition to the obligations identified as being precluded from Subcontracting under this Sec. 12, Ex. B, Part 4 of this Contract and as may be set forth in any other provision of this Contract, the following requirements obligations of Contractor under this Contract ~~may~~shall not be subcontracted or otherwise delegated to a third party:
- (a) Oversight and ~~monitoring~~Monitoring of Quality Improvement activities; and
 - (b) Adjudication of Appeals in a Member Grievance and Appeal process.
- (9) If deficiencies are identified in Subcontractor performance for any functions outlined in this ~~contract~~Contract, whether those deficiencies are identified by Contractor, by OHA, or ~~its~~their designees, Contractor agrees to require its Subcontractor to respond and remedy those deficiencies within the timeframe determined by OHA. Such obligations and timeframes shall be included in all Subcontracts.
- (10) 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 an agreement to pay) on file, signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-~~0420~~3420(5).
- (11) In accordance with Exhibit I of this Contract, Contractor shall provide every Provider ~~or~~ and Subcontractor, at the time it enters into a contract or ~~subcontract~~Subcontract, its OHA-approved written procedures for its Grievance and Appeal System ~~and ensure compliance with all federal and State requirements for member Grievance and Appeals.~~
- (12) Contractor shall ~~monitor~~Monitor the ~~Subcontractor's~~ performance of all Subcontractors on an ongoing basis and perform, at least once a year, a formal, a review of compliance ~~with delegated of all Subcontracted obligations and other~~ responsibilities ~~and Subcontractor's~~ performance, deficiencies ~~or,~~ and areas for improvement, ~~in accordance with 42 CFR 438.230(b)(1).~~ Such review shall be documented in an Annual Subcontractor Performance Report wherein Contractor, which must be completed within

sixty (60) days after the annual anniversary of the effective date of the Subcontract. Contractor shall make a conclusion in each Annual Subcontractor Performance Report as to whether a Subcontractor has complied with all the terms and conditions of this Contract that are applicable to the Work performed by Subcontractor.

- (13) The ~~review of Annual~~ Subcontractor ~~performance and compliance~~ Performance Report must include at a minimum the following elements:
- (a) An assessment of the quality of Subcontractor's performance of contracted ~~work~~ Work;
 - (b) Any complaints or ~~grievances~~ Grievances filed in relation to Subcontractor's ~~work~~ Work;
 - (c) Any late submission of reporting deliverables or incomplete data;
 - (d) Whether employees of the Subcontractor are screened and ~~monitored~~ Monitored for federal exclusion from participation in Medicaid;
 - (e) The adequacy of Subcontractor's compliance functions; and
 - (f) Any deficiencies that have been identified by OHA related to work performed by Subcontractor.
- (14) Contractor shall provide ~~OHA~~ a copy of ~~the compliance review within each Annual Subcontractor Performance Report to OHA via Administrative Notice, i~~ within thirty (30) days of completion. Contractor shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it delegates ~~has delegated~~ to a subcontractor Subcontractor.
- (15) ~~Upon identification of~~ In the event Contractor identifies deficiencies or areas for improvement, Contractor shall cause Subcontractor to take Corrective Action ~~and~~ Plan. In addition, Contractor shall notify the provide, via Administrative Notice, OHA's Contract Administrator ~~of the Corrective Action within 14 days.~~
- ~~(16)~~ ~~Contractor shall provide to OHA with~~ a copy of the ~~Corrective Action Plan~~ CAP documenting the deficiencies, ~~the~~ actions required of the Subcontractor to remedy the deficiencies, and the ~~time frame~~ time frame for completing ~~the~~ such required actions. The foregoing Administrative Notice shall be made within fourteen (14) days after providing the Corrective Action Plan to the applicable Subcontractor.
- (16) ~~(17)~~ Contractor shall provide with an update ~~OHA~~ on the status of the Corrective Action Plan at such time that the Subcontractor has been successfully removed from Corrective Action or of the Subcontractor's failure to fully remedy the underlying deficiency if the deadline for such remedy has passed ~~and the underlying deficiency has not been fully corrected.~~ Such update shall be provided to OHA via Administrative Notice within 14 days after the intended original completion date set forth in the applicable CAP.

b. Requirements for Written Agreements with Subcontractors

- (1) Contractor's ~~written agreement~~ must include in all of its Subcontracts with ~~the Subcontractor shall~~ its Subcontractors all of the following:
- (a) Provide for ~~the~~ termination of the Subcontract ~~or imposition of~~ the right to take remedial action, and impose other Sanctions by Contractor, such that Contractor's

rights substantively align with OHA's rights under this Contract, if the Subcontractor's performance is inadequate to meet the requirements of this Contract;

- (b) Provide for revocation of the delegation of activities or obligations, and specify other remedies in instances where OHA or the Contractor determine the ~~subcontractor~~Subcontractor has ~~not performed satisfactorily~~breached the terms of the Subcontract;
- (c) Require Subcontractor to comply with the payment, withholding, incentive and other requirements ~~of set forth in~~ 42 CFR §438.6 that are applicable to the Work required under the ~~subcontract~~Subcontract;
- (d) Require ~~Subcontractor~~Subcontractors to submit to Contractor Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from the Provider within timeframes for ~~encounter data~~valid, accurate, Encounter Data submission ~~outlined in as required under Ex. B, Part 8 and~~ other ~~sections-provisions~~ of this ~~contract~~Contract;
- (e) ~~Specify that the~~An express statement whereby Subcontractor agrees to comply with all ~~applicable~~Applicable Laws, including, without limitation, all Medicaid laws, rules, regulations, ~~including as well as all~~ applicable sub-regulatory guidance and contract provisions;
- (f) ~~Specify that the~~An express statement whereby Subcontractor agrees that OHA, the Oregon Secretary of State, CMS, the HHS, the Office of the Inspector General, the Comptroller General of the United States, or their duly authorized representatives and designees, or all of them or any combination of them, have the right to audit, evaluate, and inspect any books, records, contracts, computers or other electronic systems of the ~~subcontractor~~Subcontractor, or of the ~~subcontractor~~Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under ~~the CCO's this~~ Contract ~~with OHA~~;
- (g) Specify that the Subcontractor will make available, for purposes of audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Members;
- (h) Specify that the Subcontractor must respond and comply in a timely manner to any and all requests from OHA or its designee for information or documentation pertaining to ~~work~~Work outlined in this ~~contract~~Contract;
- (i) Specify that the Subcontractor agrees that the right to audit by OHA, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist ~~through for a period of ten (10) years from the final date of the contract period~~this Contract's Expiration Date or from the date of completion of any audit, whichever is later; and
- (j) Specify that if OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, OHA, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

- ~~(2) Contractor shall provide Members written notice of termination of any Subcontractor, within 15 days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Subcontractor.~~
- (k) Require Subcontractors to adopt and comply with all of Contractor's Fraud, Waste, and Abuse policies, procedures, reporting obligations, and annual Fraud, Waste, and Abuse Prevention Plan and otherwise require Subcontractor to comply with and perform all of the same obligations, terms and conditions of Contractor as set forth in Ex. B, Part 9.
- i. Unless expressly provided otherwise in the applicable provision, Subcontractors must report any Provider and Member Fraud, Waste, or Abuse to Contractor which Contractor will in turn report to OHA or the applicable agency, division, or entity. Accordingly, the timing for reporting obligations of Subcontractor must be shorter than those of Contractor's time for reporting to OHA so that Contractor may timely report such incidents to OHA in accordance with this Contract.
- (l) Require Subcontractors to allow Contractor to perform Monitoring, audit, and other review processes for the purpose of determining and reporting on compliance with the terms and conditions of the Subcontract, including, without limitation, compliance with Medical and other records security and retention policies and procedures.
- i. Contractor must document and maintain all Monitoring activities.
- (m) ~~(3) Contractor shall meet, and require its~~ Require Subcontractors and Participating Providers to meet, ~~OHP~~ the standards for timely access to care and services, ~~taking as set forth in this Contract and OAR 410-1410-3220, which includes, without limitation, providing services within a time frame that takes 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).
- (n) Require Subcontractors to report any Other Primary, third-party Insurance to which a Member may be entitled. Providers and Subcontractors must report such information to Contractor within a timeframe that enables Contractor to report such information to OHA within thirty (30) days of the Subcontractor becoming aware that the applicable Member has such coverage, as required under Sec. 16, Ex. B, Part 8 of this Contract.
- (o) Require Subcontractors to provide, in a timely manner upon request, as requested by Contractor in accordance with the request made by OHA, or as may be requested directly by OHA, with all Third-Party Liability eligibility information and any other information requested by OHA or Contractor, as applicable, in order to assist in the pursuit of financial recovery.
- (2) In the event Contractor issues or receives notice that a Subcontractor's Subcontract has been terminated, Contractor shall provide, within fifteen (15) days after receipt or

issuance of the termination notice, written notice of such termination to the Members who received regular care or primary care from the terminated Subcontractor.

~~(3)~~ ~~(4)~~ Contractor shall ~~notify OHA in writing within have thirty (30) days of terminating any Subcontractor and provide to provide~~ provide OHA with Administrative Notice that: (i) it has terminated a Subcontractor, or (ii) a Subcontractor has terminated its Subcontract with Contractor. Such Administrative Notice shall also include an updated Subcontractors and ~~Delegated~~ Entities Report.

~~(4)~~ Contractor shall ~~notify OHA in writing~~ provide Administrative Notice to OHA's Provider Services Unit within thirty (30) days of terminating any Participating Provider contract when such Participating Provider termination is a for-cause termination, including but not limited to the following:

- (a) Failure to meet requirements under the ~~contract~~ Contract or Contractor's Subcontract with its Subcontractor;
- (b) For reasons related to fraud, integrity, or quality;
- (c) Deficiencies identified through compliance ~~monitoring~~ Monitoring of the entity; or
- (d) Any other for-cause termination.

c. Subcontractors must document, maintain, and provide to Contractor all Encounter Data records that document Subcontractor's reimbursement to FQHCs Rural Health Centers and Indian Health Care Providers. All such documents and records must be provided to Contractor upon request of Contractor (who will in turn provide it to OHA).

d. Contractor understands and agrees that if Contractor is not paid or not eligible for payment by OHA for services provided, neither will Contractor's Subcontractors be paid or be eligible for payment.

13. ~~14.~~ **Minority-Owned, Woman-Owned and Emerging Small Business (“MWESB”) Participation.**

a. As noted in Oregon 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 similar 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~~ 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/COBID/, are provided an equal opportunity to compete for and participate in the performance of any subcontracts under this Contract.~~ https://www.oregon4biz.com/How-We-Can-Help/COBID/

14. ~~15.~~ **Adjustments in Service Area or Enrollment**

a. If Contractor 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 by or ~~subcontracted~~ Subcontracted with Contractor, Contractor shall provide ~~OHA with, via~~

- Administrative Notice, to OHA's Provider Services Unit, a written plan for transferring the Members and an updated DSN Provider Report, as required under Exhibit G of this Contract, at least ninety (90) days prior to the date of the implementation of such ~~action~~plan.
- b. If Contractor experiences a change which may result in the reduction or termination of any portion of Contractor's Service Area or may result in the ~~disenrollment~~Disenrollment of a substantial number of Members from Contractor, Contractor shall provide OHA, via Administrative Notice, with ~~a~~ written notice of such change and a plan for implementation at least ninety (90) days prior to the date of the implementation of such ~~action~~plan.
- (1) If Contractor ceases to be Affiliated with a MA or DSN Plan (or both), Contractor shall provide OHA, via Administrative Notice, with notice of such change. Contractor shall also provide a transition of care plan for FBDE members within one hundred and twenty (120) days prior to termination of the Affiliation.
- (2) If Contractor dissolves or otherwise shuts down its Affiliated MA or DSN Plan business (or both), or such Plans cease to do business in Contractor's Service Area, Contractor shall provide OHA, via Administrative Notice, with notice of such change. Contractor shall also provide its FBDE Members with notice one hundred and twenty (120) days prior to such change in operations.
- (3) In the event of an Affiliated MA or DSN Plan (or both) closure or reduction in Service Area, Contractor shall work with the local DHS Area Agency on Aging/Aging and People with Disabilities offices in the area(s) affected to ensure FBDE members receive choice counseling on alternative Medicare plans.
- (4) Contractor shall transition its FBDE Members to their respective new Medicare Plans in a timely manner in accordance with OAR 410-141-3061.
- c. 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.
- d. OHA reserves the right to waive or otherwise amend the required ~~notice~~time period in ~~certain circumstances~~which Administrative Notice is required to be provided to OHA relating to the termination or loss of a Provider, Provider Group, or Service Area, including but not limited to:
- (1) If Contractor must terminate a Provider or group due to circumstances that could compromise Member care;
- (2) If a Provider or group terminates its ~~subcontract~~Subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required ninety (90) day notice; or,
- (3) At OHA's discretion.
- e. OHA will reassign any transferring ~~members~~Members to another Managed Care Plan in the ~~service area~~Service Area with sufficient capacity or may seek other avenues to provide services to ~~members~~Members.
- f. Contractor retains responsibility for ensuring sufficient capacity and solvency and providing all Covered Services through the end of the ninety (90) day transition period ~~without limitation,~~forto all Members for which the Contractor received a CCO Payment.

- g. If Members are required to ~~disenroll~~Disenroll from Contractor pursuant to this ~~section~~Sec. 14, Ex. B, Part 4 of this Contract, Contractor retains responsibility for providing access to 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. In accordance with Sec. 10, Ex. D of this Contract (and notwithstanding the applicability of such provision to termination of this Contract), Contractor shall cooperate in notifying the affected Members and coordinating care and transferring records during the transition to the accepting plan, to the ~~member~~Member's new Providers, and to any designated PCP.
- h. Contractor shall complete submission and corrections to ~~encounter data~~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~~Sec. 14, Ex. B, Part 4 of this Contract. OHA ~~may~~shall have the right, in its discretion, to withhold up to 20% of Contractor's monthly CCO Payment (subject to actuarial considerations) until all contractual obligations under this Contract have been met to OHA's satisfaction. Contractor's failure to complete or ensure completion of said contractual obligations within a timeframe defined by OHA will result in a forfeiture of the amount withheld.
- i. If Contractor is assigned or transferred Clients pursuant to this section, Contractor accepts all assigned or transferred Clients without regard to the Enrollment exemptions in OAR 410-141-3060.
- j. 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 of this Contract:
- 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.
- k. 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 of this Contract:
- (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 of this Contract, 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.

[Remainder of page intentionally left blank]

[Exhibit B, Parts 5 through 7 are reserved.]

[\[Remainder of page intentionally left blank\]](#)

Exhibit B –Statement of Work - Part 8—~~Operations~~

~~1-~~Accountability and Transparency of Operations

1. Record Keeping Requirements

- a. In accordance ORS 414.625 (m), Contractor shall ~~adhere to any industry standards, and state and federal law~~ use best practices in the management of its finances, contracts, claims processing, payment functions and Provider Networks ~~consistent with ORS 414.625~~.
- b. Contractor shall provide OHA, ~~and require~~ its ~~Subcontractors to provide~~ external quality review organization, or any of its other designees, agents, or subcontractors (or any combination, or all, of them) with timely access to Contractor's records and facilities and cooperate with OHA ~~such parties in the~~ 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 for the purposes of Monitoring compliance with this Contract, including but not limited to verification of services actually provided, and for developing, Monitoring, and monitoring~~ analyzing performance and outcomes. Collection methods with which Contractor must cooperate may include, without limitation: consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other means determined by OHA.
- c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures ~~defined~~ established by OHA for evaluating ~~CCO~~ Contractor's 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~~ PCPCHs, the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA, ~~CMS or its~~ external review organizations, or any of its other designees, agents, or subcontractors (or any combination, or all, of them).
- d. Contractor shall ensure record keeping policies and procedures are in accordance with 42 CFR §438.3(u). ~~Contractor shall keep documents specified in~~ Notwithstanding any shorter retention period that may be required under 42 CFR §§438.5(c), 438.604, 438.606, and 438.608—and 438.610 for no less than 10 years, Contractor shall maintain all records and documents specified in Section 15 of Ex. D to this Contract
- e. Contractor shall develop and maintain a record keeping system that meets all of the following standards:
 - (1) Includes Provides sufficient detail and clarity to permit internal and external review to validate ~~encounter~~ Encounter Data submissions and to assure Members have been, and are being, provided with Medically Appropriate services ~~are provided~~ consistent with the documented needs of the Member; ~~and~~
 - (2) Conforms to accepted professional practice; and any and all Applicable Laws related thereto;
 - (3) Is supported by written policies and procedures; and
 - (4) 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.
- f. Contractor ~~shall ensure that the record keeping systems of its Participating Providers conform to the standards of this section.~~
- ~~g. Contractor shall review all~~must review all of its internal internal record keeping policies and procedures on a biennial basis or as required by other sections in this Contract. ~~Contractor shall submit timely, accurate and complete reports to OHA. OHA will post on its web site information about required reports, including the type of report, its location in Contract, the reporting due date, and where the report is to be submitted.~~
- ~~h. 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 B, Part 9.~~
- ~~i.~~
- g. Contractor shall inform OHA if it has been accredited by a private independent accrediting entity. If the Contractor has been so accredited, Contractor shall authorize the private independent accrediting entity to provide OHA a copy of its most recent accreditation review, including:
- (1) Accreditation status, survey type, and level (as applicable);
 - (2) Accreditation results, including recommended actions or improvements, ~~corrective action plans~~Corrective Action Plans, and summaries of findings; and
 - (3) Expiration date of the accreditation.

2. Privacy, Security, and Retention of Records

- a. ~~Maintenance and Security: In accordance with OAR 410-141-3180(1) Contractor shall ensure maintenance of a s~~ record keeping system ~~that includes maintaining~~must ensure the security of its records, including Clinical Records that document the Covered Services provided to Members, 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 Member.~~ Contractor ~~shall~~must have written policies and procedures ~~establishing adherence to the aforementioned regulations and shall communicate these policies and procedures to its Subcontractors, regularly monitor its Subcontractors' compliance with these policies and procedures and take any Corrective Action necessary to ensure Subcontractor 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~~regarding the access, use, and transmission of records that comply with ORS ~~192.561, 413.171, and 414.679; OAR 410-141-3180; OAR 943-014-0300 through 943-014-0320; and, OAR 943-120-0000 through 943-120-0200,~~ and this Sec. 2, of this Ex. B, Part 8. Contractor must also allow OHA to Monitor compliance with Contractor's Records Security Policies.
- b. In accordance with OAR 410-141-0180(4)(b) and 410-141-3180(2), Members must have access to ~~the Member's~~their own personal health information in the manner provided in 45 CFR §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 its

Participating Providers may charge ~~the Member~~Members for reasonable duplication costs when ~~the Member seeks~~they request copies of ~~his or her~~their records.

- c. ~~Notwithstanding~~Pursuant to ORS 414.679(3) and notwithstanding ORS 179.505, Contractor, ~~and its Provider Network and programs administered by OHA and DHS may,~~ shall 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 meet the Triple Aim goals of providing quality of care, ~~lower~~lowering the cost of care, and ~~improve~~improving the health and well-being of the Members.
- d. Pursuant to ORS 414.679(4) Contractor and its Provider Network ~~may~~shall use and disclose sensitive diagnosis information, including HIV and other health and mental health diagnoses, 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~~all other Applicable Laws relating to health information privacy ~~requirements~~. Redisclosure of individually identifiable information outside of ~~the Contractor's organization~~ and ~~the its~~ 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~~is only permitted in accordance with Applicable Laws relating to health information privacy ~~requirements~~.
- e. Pursuant to ORS 413.175 and OAR 943-014-0010(3) and (4), Contractor and its Provider Network may disclose information about Members to the OHA and DHS for the purpose of administering the laws of Oregon.

3. Access to Records

Contractor ~~shall cooperate with, OHA, the Department of Justice Medicaid Fraud Control Unit (MFCU), 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.~~ must maintain its records and allow access to all records, documents, information, systems and facilities in accordance with Ex. D, Sec. 15 to this Contract.

~~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.~~

~~Contractor shall retain, and shall require its Participating Providers to retain, Clinical Records for ten 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 ten-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.~~

~~Contractor understands that information prepared, owned, used or retained by OHA is subject to the Public Records Law, ORS 192.311 et seq.~~

4. 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~~Affiliated with Contractor in accordance with OAR 410-141-3420 ~~Billing~~.

b. Contractor understands and ~~Payment.~~

- ~~b.~~ ~~Contractor shall ensure~~agrees 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~~(e.g. Third Party Resource recovery), Contractor ~~and its Subcontractors may will~~ not be compensated for Work performed under this Contract from any other agency, division, or department of the State, nor from any other source including the federal government.
- d. Contractor shall comply with Section 6507 of ~~PPACA~~Patient Protection Affordable Care Act regarding the use of National Correct Coding Initiative ~~(NCCI)~~.
- e. Certain federal laws governing reimbursement of ~~FQHCs~~services provided by Federally Qualified Health Centers, Rural Health Centers, and Indian Health Care Providers may require OHA to provide supplemental payments to those entities, even though those entities have subcontracted with Contractor to provide Covered Services ~~and including Indian Health Care Providers that do not have a subcontract.~~ This may also be the case with IHCPs who have not entered into Subcontracts with ~~the~~ Contractor. These supplemental payments are outside the scope of this Contract and do not violate ~~the~~this Contract's prohibition on dual ~~payment contained herein~~payments. Contractor ~~shall~~must maintain ~~encounter data~~Encounter Data records and ~~such additional Subcontract~~any other information relating thereto documenting Contractor's reimbursement to FQHCs, Rural Health Centers ~~and Indian Health Care Providers~~, and ~~to~~IHCPs, and provide such information to OHA upon request. Contractor ~~shall~~must also provide information documenting Contractor's reimbursement to non-participating ~~Indian Health Care Providers~~IHCPs to OHA upon request.
- f. Consistent with 42 CFR §438.106 and 42 CFR §438.230, Contractor shall prohibit Subcontractors ~~and, including~~ 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.~~ ~~g.~~ Contractor and its Providers shall comply with Oregon House Bill 2398 (Engrossed) 2017 which requires Providers to:
- (1) Wait ninety (90) days after submitting the claim before assigning a claim to a collection agency or other similar entity for the purpose of recovering fees from the patient;
 - (2) Query OHA's database to confirm eligibility for medical assistance;
 - (3) Assign any outstanding claims to a collection agency or other similar entity for the purpose of recovering fees from a patient *only if*, at the time of service, the patient was not eligible for medical assistance.
- g. Contractor's Providers shall not bill a Member for Non-Covered Services unless the Provider complied with the requirements set forth OAR 410-120-1280(3)(h) prior to providing any of the Non-Covered Services.
- (1) Contractor may work with its Affiliated Medicare Advantage Plan or its Affiliated Dual Special Needs Plan (or both as applicable) to implement a process by which Medicare Providers either complete a pre-service coverage determination.
- h.** Contractor must reimburse ~~providers~~Providers for all ~~covered services~~Covered Services delivered in integrated clinics by qualified ~~providers~~Providers.

- ~~i.~~ i. Contractor ~~shall~~must support a ~~warm handoff~~Warm Handoff of a Member between levels or ~~episodes~~Episodes of care for a member ~~Care~~.

~~j.~~

5. Claims Payment

- a. Claims that are subject to payment under this Contract by Contractor ~~from~~for services provided by 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~~must pay Non-Participating Providers for Covered Services, consistent with the provisions of ORS 414.743, OAR 410-120-~~1295(2)~~, OAR 410-120-1340, and OAR 410-141-3420.
- b. Pursuant to OAR 410-141-3420, Contractor ~~may~~shall require ~~Participating~~ Providers to submit all billings for Members to Contractor within four months of the Date of Service, ~~except~~. However, Providers may, if necessary, submit its billings to Contractor within twelve (12) months from the date of Service under the following circumstances:
- (1) Billing is delayed due to ~~eligibility issues~~retroactive deletions or enrollments;
 - (2) Pregnancy of the Member;
 - (3) Medicare is the primary payer, unless Contractor is responsible for Medicare reimbursement;
 - (4) Cases involving ~~third party resources~~;
 - ~~(5) Covered Services provided by Non-Participating Providers that are enrolled with OHA; or~~Third-Party Resources; or
 - ~~(6) Other circumstances in which there are reasonable grounds for delay (which does not include a Subcontractor cases that delay the initial billing to Contractor, unless the delay was due to the Provider's failure to verify a Member's eligibility).~~(5) (6) Other circumstances that delay the initial billing to Contractor, unless the delay was due to the Provider's failure to verify a Member's eligibility).
- c. Contractor ~~shall~~must have written policies and procedures for processing claims submitted for payment from any source. The policies and procedures ~~shall~~must specify time frames for and include or require (or both) all of the following:
- (1) Date stamping claims when received;
 - (2) Determining within a specific number of days from receipt whether a claim is ~~valid~~Valid or ~~non-valid~~invalid;
 - (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~~to determine whether a claim is Valid or invalid;
 - (5) Sending notice ~~of~~to the Member regarding Contractor's decision with regarding the approval or denial of a claim and if denied, the notice must include information on the ~~member~~Member's Grievance and Appeal rights ~~to the Member when the determination is made to deny the claim~~;
 - (6) Making information ~~on~~about a Member's Grievance and Appeal rights available upon request to a Member's authorized Member Representative who may be either a Participating Provider or a Non-~~participating~~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. ~~In accordance with 42 §CFR 447.45 and 42 CFR §447.46,~~ Contractor ~~shall~~must pay or deny at least ninety percent (90%) of Valid Claims within thirty (30) days of receipt and at least ninety-nine percent (99%) of Valid Claims within ninety (90) days of receipt. Contractors shall make an initial determination on ninety-nine percent (99%) of all Valid Claims submitted within sixty (60) days of receipt. The Date of Receipt of a Claim is the date ~~the~~ Contractor receives ~~the~~ a claim, as indicated by its date stamp ~~on the claim~~thereon. Contractor and its Subcontractors may, by mutual agreement, ~~establish an alternative~~agree to a different payment schedule ~~not to exceed—provided that~~ the minimum requirements required under 42 §CFR 447.45 and 42 CFR §447.46 are met.
- e. ~~Claims that are subject to payment under this Contract by Contractor from~~ If a Non-Participating ~~Providers~~Provider who ~~are~~is enrolled with OHA ~~will be billed~~is entitled to payment from Contractor ~~consistent~~for services provided to a Member, the Non-Participating Provider must bill Contractor in accordance with the requirements ~~of set forth in~~ OAR 410-120-1280 and 410-120-1300. If a Provider is not enrolled with OHA on the Date of Service, but the Provider subsequently becomes enrolled pursuant to OAR 410-120-1260(6) ~~“Provider Enrollment”, the claim shall be processed by~~ Contractor shall process such claim 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 Members who are (i) enrolled with ~~the~~ Contractor ~~who~~as AI/AN and (ii) are eligible to receive services from such Providers; Payment to IHCP for Covered Services shall be made as follows:
- (1) Participating ~~Indian Health Care Providers~~IHCPs 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~~IHCPs 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~~IHCPs 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~~IHCP for such services.
- g. Contractor shall make prompt payment to ~~Indian Health Care Providers~~IHCPs including Indian ~~Tribes~~Tribes, Tribal ~~Organization~~Organizations, 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 valid claims from providers within 90 days of the date of receipt per 42 §CFR 447.45 and 42 CFR §447.46~~Organizations, in the same time frame required under Para. d above, of this Sec. 5, Ex. B, Part 8.
- 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 (IHCP)~~, Indian Health Services (~~HHS~~); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through ~~referral~~a Referral under ~~contract health services (CHS)~~Contract Health Services.

- i. Contractor ~~shall~~must pay for Emergency Services that are ~~received from~~performed by 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, and provided to OHA as may be specified by OHA from time to time; and
- (4) ~~Not~~In accordance with 42 CFR §447.26(b) not make payment to Providers for Health Care-Acquired Conditions or Other Provider-Preventable Conditions that ~~are Health Care-Acquired Conditions or that~~ meet the following criteria ~~as specified in 42 CFR §447.26(b)~~:
 - (a) Is identified in the State plan.
 - (b) 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~~Evidence-Based guidelines.
 - (c) Has a negative consequence for the Member.
 - (d) Is auditable.
 - (e) 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.

6. Medicare Payers and Providers

- a. ~~For those Contractors affiliated with~~If Contractor is an Affiliate of or ~~contracted~~contracts with an entity that provides services as a Medicare Advantage plan serving Fully Full Benefit Dual EligiblesEligible clients, Contractor ~~shall~~must demonstrate on a yearly basis that its Provider Network is adequate to provide both the Medicare and the Medicaid Covered Services to its Fully Full Benefit Dual Eligible population, including Contractor's Members. The adequacy standards may be determined by Contractor ~~shall identify its Providers' Medicaid participation in accordance with the applicable rules and utilizing the Section 1876 Cost Plan Network Adequacy Guidance handbook located at the following URL:~~

<https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/index.html>

- (1) In the event CMS audits Contractor's Affiliated MA Plan or its Affiliated DNS Plan (or both of them), Contractor shall provide the results of any such audit to OHA via Administrative Notice within ninety (90) days of receipt.

- (2) In the event Contractor's Affiliated MA Plan or its Affiliated DNS Plan (or both of them) fails to meet network adequacy standards as determined by CMS, Contractor shall:
- (a) Provide Members with access to specialty care service Providers in accordance with 42 CFR §422.112(a)(3), at the Member's in-network cost sharing level for the applicable specialty in Contractor's Service Area; and
- (b) In accordance with 42 CFR §422.112(a)(2), Make other arrangements to ensure access to medically necessary specialty care if referrals from PCPs are required but Contractor's Provider Network is not adequate to enable its FBDEs to select a PCP.
- b. Pursuant to OAR 410-141-XXXX(2)(f)(D) Contractor ~~shall~~ must coordinate ~~care and benefits that are Covered Services, if Medically Appropriate,~~ with Medicare payers and Providers ~~as Medically Appropriate~~ for the ~~purpose of achieving appropriate health outcomes for~~ care and benefits of Members who are eligible for both Medicaid and Medicare.
- c. Contractor and, if applicable, Affiliated MA and DSN Plans, shall, in accordance with 42 CFR §438.3(t), enter into a Coordination of Benefits Agreement with CMS and obtain a COBA number and coordinate with COBA in order to participate in the automated crossover claims process for FBDE Members. If Contractor and its Affiliated MA and DSN Plans are not currently utilizing the automated crossover claims system for processing claims for FBDE Members, Contractor must provide OHA, via Administrative Notice, with a plan for Contractor and its Affiliated MA and DSN Plans transitioning to the use of such system by no later than January 1, 2021. Such plan must be submitted to OHA by no later than March 30, 2020.
- (1) Contractor shall ensure its Providers are notified of billing processes for crossover claims processing consistent with Para. a above of this Sec. 6, Ex. B, Part 8.
- d. ~~e.~~ Pursuant to OAR 410-141-3420(9) Contractor is responsible for paying Medicare deductibles, coinsurance, and Co-Payments in accordance with the State's methodology up to Medicare's or Contractor's allowable amounts for all Medicare Part A and Part B 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~~ after adjudication with Medicare or a Medicare Advantage Plan. Providers must be enrolled with Oregon Medicaid to receive cost sharing payments and Contractor should provide non-enrolled Providers with information about enrolling with Oregon Medicaid to receive sharing payments. Contractor shall require Fee for Service Medicare Providers who provide services to FBDE Members to comply with OAR 410-120-1280(8)(j). Contractor is responsible for such paying such amounts to Non-Participating Providers when urgent care and emergency services are provided to such Members.
- e. ~~d.~~ Contractor is not responsible for Medicare deductibles, coinsurance and ~~co~~Co-payments Payments for skilled ~~nursing facility~~ Nursing Facility benefit days ~~21~~ twenty-one (21) through one hundred (100).
- f. ~~e.~~ Contractors that are affiliated with If Contractor is an Affiliate of, or ~~contracted~~ contracts with, an entity that provides services as a Medicare Advantage plan serving ~~Fully Dual Eligible~~ FBDE Members ~~for Medicare and Medicaid,~~ Contractor may not impose cost-sharing requirements on ~~Fully Dual Eligible~~ FBDE Members and ~~QMB~~ Qualified Medicare Beneficiaries that would

exceed the amounts permitted by OHP if the Member is not enrolled in the Contractor's Medicare Advantage plan.

- ~~g.~~ ~~f.~~ Contractor ~~shall~~must ~~provide an annual~~ report to ~~the~~OHA ~~Contract Administration Unit~~that identifies its affiliation or ~~contract~~contracts with Medicare Advantage Plan entities in Contractor's Service Area(s). Contractor shall provide its report to OHA via Administrative Notice by no later than November 15 of each Contract Year using the Affiliated Medicare Advantage Plan Report ~~which is available~~located on the CCO Contract Reports Web Site~~Forms Website~~. Contractor ~~shall~~must promptly update its Affiliated Medicare Advantage Report ~~at~~prior to November 15 any time there has been a ~~Material Change~~material change in Contractor's operations that would affect adequate capacity and services, and ~~annually no later than November 15, before the new Medicare plan year begins, and~~ upon OHA's request.

7. Eligibility Verification for Fully Dual Eligible Members

- ~~a.~~ a. If Contractor is ~~affiliated~~Affiliated with or contracted with a Medicare Advantage plan for ~~Fully Dual Eligibles~~FBDEs for Medicare and Medicaid, Contractor shall use 834 Electronic Data Interchange transaction set and 270/271 Health Care Eligibility Benefit Inquiry and Response transaction sets, and share Member information in the EDI 834 Benefit Enrollment and Maintenance files with its Affiliated MA or DSN Plans (or both of them as applicable).
- ~~b.~~ b. Contractor shall require its Providers to verify current Member eligibility using the ~~AVR~~Automated Voice Response system, 270/271 Health Care Eligibility Benefit Inquiry and Response transactions, 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 410-141-3420(9), 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.~~

8. All Payers All Claims (~~APAC~~) Reporting Program

Contractor ~~shall~~must participate in the ~~APAC~~All Payers All Claims reporting ~~system~~program established by OHA in ~~ORS 442.464 and 442.466~~accordance with its authority under 442.466 and as implemented by OAR 409-025-1000 through 409-025-0170. Data submitted under this Contract may be used by OHA for ~~the purposes related to obligations under~~identified in ORS ~~442.464 and 442.466~~ and disclosed in accordance with OAR ~~409-025-0100 to 0160 and~~ OAR 409-025-0170. ~~Submission of encounter data by~~Providing Encounter Data to OHA in accordance with this Contract will partially fulfill Contractor's responsibility for APAC reporting. ~~Contractor's submission.~~ ~~In addition to of Alternative Payment Methodology data to APAC, together with~~ the submission of encounter data in accordance with this Contract, contractor submission of alternative payment methodology data to APACits Encounter Data, will wholly 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 reporting.~~ Additional information regarding compliance and enforcement ~~under OAR 409-025-0150 as well as under this Contract.~~ of the APAC reporting program, including the method, format, data required to be submitted and applicable due dates is found at:
<https://www.oregon.gov/oha/hpa/analytics/Pages/All-Payer-All-Claims.aspx>

9. Administrative Performance Program

- ~~a.~~ The Administrative Performance (AP) Standard utilizes the AP Penalty (APP) methodology described in this section. The APP 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 APP process. The APP 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 APP methodology and calculations:
- ~~(1)~~ 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.
 - ~~(2)~~ OHA will send Contractor a Subject Month report within 30 days after the end of the Final Submission Month.
 - ~~(3)~~ 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.
 - ~~(4)~~ 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 APP 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.
 - ~~(5)~~ 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 APP. The decision on administrative review shall result in a final Subject Month report if an appeal was timely filed.
 - ~~(6)~~ 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.
 - ~~(7)~~ 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.
 - ~~(8)~~ 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.
- 10. Valid 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 Accredited Standardized Committee (ASC) X12N 834 and ASC X12N 835, formats as appropriate in accordance with OARs and OHA requirements.~~
- ~~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 certify and attest that based on best information, knowledge, and belief, the data, documentation, and information submitted in its encounter claims is accurate, complete, and truthful in accordance with 42 CFR 438.604 and 438.606. Certification must be provided by the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. If the signing authority is delegated to another individual, the Chief Executive Officer or Chief Financial Officer retains final responsibility for the certification.~~
- ~~d. Contractor shall demonstrate to OHA through proof of enrollment information, Encounter Data Certification and Encounter Data Validation that Contractor attests to the accuracy, completeness and truthfulness of information required by OHA. Contractor shall submit the following reports to OHA:~~
- ~~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.~~
- ~~e. 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).~~
- ~~f. Contractor shall obtain a Coordination of Benefits Agreement (COBA) number and coordinate with COBA to receive direct crossover claims for dually eligible members with traditional Medicare per 42 CFR 438.3(t).~~
- ~~g. OHA will conduct periodic encounter data validation studies of the Contractor's encounter submissions. These studies will review statistically valid random samples of encounter claims to establish a baseline error rate across Contractor's provider network.~~
- ~~h. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness, sufficiency of documentation, and omission of encounters.~~
- ~~i. OHA will conduct encounter data validation studies to identify opportunities for technical assistance and establish a baseline error rate. Contractor shall takes steps to improve the accuracy of its encounter data and improve upon the baseline error rate. For contract years 2+, Contractor's failure to improve upon the baseline error rate may result in financial penalties or sanctions, and~~

~~may require a corrective action plan for noncompliance with related encounter submission requirements.~~

- ~~j. Encounter data validation studies may include claims data used to calculate quality metrics or incentive pool metrics.~~

~~11. Encounter Data Submission and Processing~~

10.

In order to ensure the integrity of the Medicaid program, OHA and CMS require compliance with a wide range of obligations relating to the verification of services provided to Members. One means by which compliance is verified is the collection and reporting data relating to claims for all services provided to Members, whether such claims are for Covered Services or other health-related services. Accordingly, Contractor is required, pursuant to 42 CFR §438.604, 42 CFR §438.606, and OAR 410-141-3430 to submit and certify to OHA the accuracy and truthfulness of Encounter Data, which is then subject to OHA for review and verification. In addition to ensuring the integrity of the Medicaid program, OHA also relies on Encounter Data to: (i) set Capitation Rates, (ii) calculate Quality Incentive Payments, and (iii) analyze access to and effectiveness of care provided to Members. Secs. 9 through 15 of this Ex. B, Part 8, sets forth the criteria, processes, and high-level obligations with which Contractor must comply regarding the collection and submission of Encounter Data. The obligations set forth in Sections 9 through 15 of this Ex. B, Part 8 are not exclusive and are in addition to all of Contractor's other obligations under this Contract regarding the submission of Encounter Data.

- a. Contractor ~~shall~~must submit two different Valid Encounter Data sets at least once per calendar month, ~~including by no later than the Final Submission Month.~~ One Valid Encounter Data set will include Non-Pharmacy Data, Encounter Data, which is related to dental, institutional, and professional encounters and the second Valid Encounter Data set will include data related Pharmacy Encounter Data . All Valid Encounter Data sets shall be submitted in accordance with the AP Standard not later than the last day of the Final Submission Month (described below in Sec. 13 of this Ex. B, Part 8).
- b. OHA will hold, and Contractor is encouraged to attend, monthly All Plan System Technical Meetings via teleconference. The APST Meetings are open to all CCOs for the purpose of addressing on-going business and technology system related issues. The monthly APST Meetings will be held on the Wednesday before the third Thursday of each month. In the event an APST Meeting is cancelled or rescheduled, OHA will provide Contractor's Contract Administrator with Administrative Notice of any such change.
- ~~c.~~ b. Contractor ~~shall~~must submit ~~valid all~~ Valid Encounter Data ~~on forms or formats specified by OHA and~~ in accordance with OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200, ~~and on forms or in~~ formats specified by OHA in the Encounter Data Submission Guidelines located at:
- ~~e.~~ The Encounter Data submitted must represent no less than 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).
- <https://www.oregon.gov/oha/HSD/OHP/Pages/Encounter-Data.aspx>
- d. ~~Contractor shall correct errors in Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5%~~

~~of any Encounter Data submission cannot be processed because of missing or erroneous information.~~ In accordance with section 1903(m)(2)(A)(xi) of the Social Security Act, Contractor must maintain all Encounter Data in a manner that is sufficient to identify the actual Provider who delivered the services to the Member.

- e. ~~For purposes of this section, the AP Standard allows for Contractor delay of no more than 5% of non-pharmacy encounter claims for the Subject Month with prior notification to OHA. Contractor may submit documentation to OHA citing specific circumstances that will result in a delay to Contractor's timely submittal of Valid Encounter Data. All Valid Encounter Data submitted must be submitted in the timeframes and meet the criteria set forth in OAR 410-141-3430. Additional details regarding the deadlines for submission of all Encounter Data subject to Claims Adjudication are set forth in Secs. 11 and 12 below of this Ex. B, Part 8.~~
- f. ~~If Contractor submits documentation of a delay in encounter claims submission, OHA will review the documentation and make a determination within 30 days on whether the circumstances cited are Acceptable and that a Corrective Action Plan is not necessary to remedy the deficiency. If OHA is unable to process Encounter Data due to missing or erroneous information, Contractor must correct errors in such Encounter Data as directed by OHA.~~
- g. ~~These "Acceptable" circumstances may include, but are not limited to:~~ If Contractor fails to submit all of its Adjudicated Encounter Data within forty-five (45) days of a Member receiving Services, Contractor must submit a written Notice of Encounter Data Delay information OHA of the reasons for the delay, which must be an acceptable reason, as set forth in OAR 410-141-3430(4)(a)(C), for the delay. Any Notice of Encounter Data Delay shall be provided, via email, to Contractor's Encounter Data liaison on or before the date Contractor's Encounter Data is required to be submitted. Upon receipt of Contractor's Notice of Encounter Data Delay, OHA will review such Notice and make a determination whether the circumstances cited are acceptable. OHA will advise Contractor's Contract Administrator via Administrative Notice within thirty (30) days of receipt whether such circumstances are acceptable. In accordance with OAR 410-141-3430(4)(a)(C), acceptable reasons for a delay in submission of Encounter Data are as follows:

- (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 pregnancy;
- (5) Hardware or software modifications to Contractor's system that would prevent timely submission or correction of ~~encounter data~~Encounter Data; or
- (6) OHA recognized system issues preventing timely submission of Encounter Data including systems issues preventing timely submission to the All Payer All Claims database.

~~Unanticipated or justified delays that prevented Contractor's timely and accurate submission must include an effective plan for resolution and must be reported by Contractor to OHA and agreed to in writing by OHA prior to the end of the Final Submission Month.~~

~~12. Encounter Claims Data~~

- ~~h. Delays, regardless of the reason and regardless of whether Contractor provided a Notice of Encounter Data Delay, in the timely submission of Encounter Data may result in OHA requiring Contractor to agree to an informal remediation process set forth in a Compliance Status Agreement. The Compliance Status Agreement shall require Contractor to, and Contractor shall agree to, take certain steps to resolve issues that are causing delays and to implement processes that will prevent delays in the future. ...~~
- ~~i. OHA will conduct periodic Encounter Data validation studies of the Contractor's Encounter Data reports. These studies will review statistically valid random samples of Encounter Data claims to establish a baseline error rate across Contractor's Provider Network and to identify opportunities for technical assistance.~~
- ~~j. The results of Encounter Data validation studies may also be used to calculate quality metrics or incentive pool metrics, or both.~~
- ~~k. The Encounter Data validation studies may also compare recorded utilization information from medical records or other sources with the Contractor's submitted Encounter Data. Any and all Covered Services may be validated as part of these studies. The criteria used in Encounter Data validation studies may include timeliness, correctness, sufficiency of documentation, and omission of Encounters.~~
- ~~l. Based on the results of OHA's Encounter Data validation studies, OHA shall have the right to require Contractor to take steps to improve the accuracy of its Encounter Data and improve upon the baseline error rate by pursuing any and all of its rights and remedies in accordance with Secs. 1 through 9 of Ex. B, Part 9 and Sec. 9 of Ex. D of this Contract..~~
- ~~m. Notwithstanding Para. 1 above of this Section 9. Ex. B, Part 8, prior to imposing any Sanctions, including any Corrective Action, OHA will have the right, but not the obligation, to require Contractor to take other remedial steps to improve upon its error rate or cure other failures to comply with the Encounter Data submission standards or processing obligations. Such remedial steps may include, without limitation, entering into a formal work plan wherein OHA and Contractor shall work together to ensure the accuracy of Contractor's Encounter Data prior to being submitted for review and acceptance.~~

11. Encounter Data Submission Processes

All Encounter Data must be provided to OHA through OHA's secure electronic portal in accordance with 45 CFR Part 162, OAR 410-141-3430(1), OAR 943-120-0100 through 943-120-0200 and as more specifically as set forth below in this Sec. 10 and Secs. 11-12 of this Ex. B, Part 8.

- ~~a. Contractor shall provide all Valid Encounter Data electronically in accordance with 45 CFR Part 162, OAR 410-141-3430(1), OAR 943-120-0100 through 943-120-0200 using HIPAA Transactions and Codes Sets or the National Council for Prescription Drug Programs Standards and Accredited Standardized Committee X12N 837 and ASC X12N 835, formats as appropriate in accordance with OAR and OHA requirements.~~
- ~~b. In order to submit its Valid Encounter Data Contractor must first become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transmission Rules as set forth in OAR 943-120-0100 through 943-120-0200.~~
- ~~c. In accordance with 42 CFR §438.3(t), Contractor shall enter into a Coordination of Benefits Agreement with CMS and obtain a COBA number and coordinate with COBA in order to~~

participate in the automated crossover claims process for dually eligible Medicare and Medicaid Members

- d.** In accordance with 42 CFR §438.604, 42 CFR §438.606, each monthly Encounter Data report shall be provided to OHA together with an Encounter Data certification and validation report form pursuant to which Contractor certifies and attests that based on its best information, knowledge, and belief, that the data, documentation, and information submitted in its Encounter Data report is accurate, complete, and truthful. Certification and attestation must be made by the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. If the signing authority is delegated to another individual, the Chief Executive Officer or Chief Financial Officer, as applicable, retains final responsibility for the certification. The Encounter Data certification and validation report is located at: <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>.

12. Additional Encounter Data Submission Requirements: Non-Pharmacy) Encounter Data

- a.** In accordance with Sec. 9, Paras. a.-f, and Sec. 10 above of this Ex. B, Part 8, Contractor shall submit ~~all valid unduplicated~~ to OHA at least once per month all Valid Non-Pharmacy Encounter Data that was Adjudicated in the subject month. . . All other remaining unreported Non-Pharmacy Encounter Data for a Subject Month must be reported within forty-five (45) days from the date of service. If Contractor fails to provide OHA with all of its Non-Pharmacy Encounter Data ~~to OHA~~ for a subject month within forty-five (45) days ~~of from~~ the ~~Claims Adjudication date. The Claims Adjudication date is the date of Contractor's payment or denial. Corrective Action will be initiated if the Encounter Data~~ date of service, and such remaining data is not submitted ~~are over 45~~ within one hundred and eighty (180) days ~~after of~~ the ~~Claims Adjudication date of service~~, or if the submissions of duplicate claims or other errors exceed five percent (5%) per month, OHA shall have the right to exercise its rights under Sec. 9, Par. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.
- ~~**b.** Contractor shall correct errors in Encounter Data if the Encounter Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5% of any Encounter Data submission cannot be processed because of missing or erroneous information.~~
- ~~**c.** Contractor shall submit all Encounter Data including the allowed amount and paid amount as required by 42 CFR 438.818, if allowed through state transaction/submission process.~~
- b.** ~~d.~~ OHA will notify Contractor's Contract Administrator via Administrative Notice 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~~ identified in such notification is referred to as "Encounter Data Requiring Correction." OHA will not necessarily notify Contractor of report errors.
- c.** ~~e.~~ Contractor shall ~~submit~~ resubmit, in accordance with the applicable processes set forth in Sec.10 above of this Ex. B, Part 8, all of its corrections to ~~all~~ the Encounter Data Requiring Correction within sixty-three (63) days of the date OHA sends Contractor notice ~~of the required corrections. In the event Contractor fails to resubmit, or resubmits but fails to correct, its Encounter Data Requiring Correction that are not corrected to be Valid Encounter Data within sixty-three (63) days of OHA notification are subject to Corrective Action.~~

13. ~~13.~~ Encounter Pharmacy Data

- ~~a. The Encounter Pharmacy Data submitted must represent no less than 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).~~
- ~~a. b.~~ In accordance with Sec. 9, Paras. a.-f, and Sec. 10 above of this Ex. B, Part 8 and OAR 410-141-3430(4)(b)(B), Contractor shall directly submit all valid, accepted liability, unduplicated, or be submitted on behalf of Contractor by Contractor's PBM, at least once each month all Valid Pharmacy Encounter Pharmacy Data to OHA within Adjudicated in a Subject Month to OHA, but in no event more than forty-five (45) days of after the dispense date of service. Corrective action will be initiated if the If Contractor's Pharmacy Encounter Pharmacy Data is submitted are over more than forty-five (45) days after the dispense Claims Adjudication date or if the submission of duplicate claims or other errors exceed five percent (5%) per month. OHA shall have the right to exercise its rights under Sec. 9, Par. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.
- ~~e. Contractor shall correct errors in Encounter Pharmacy Data if the Encounter Pharmacy Data cannot be processed because of missing or erroneous information. Corrective Action will be initiated if more than 5% of any pharmacy data submission cannot be processed because of missing or erroneous information.~~
- ~~b.~~ All Pharmacy Encounter Data must meet the content standards required by the NCPDP which can be obtained by contacting the NCPDP or by accessing the NCPDP website located at: <http://www.ncdp.org/>
- ~~c.~~ d. OHA will notify Contractor's Contract Administrator, via Administrative Notice, 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 identified in such notification is referred to as "Pharmacy Data Requiring Correction." OHA will not necessarily notify Contractor of report errors.
- ~~d.~~ Contractor shall resubmit, in accordance with the applicable processes set forth in Sec.10 above of this Ex. B, Part 8, all of its corrections to the Pharmacy Data Requiring Correction within sixty-three (63) days, or a shorter period as directed by OHA, of the date OHA sends Contractor notice of the required corrections. In the event Contractor fails to resubmit, or resubmits but fails to correct, its Pharmacy Data Requiring Correction within sixty-three (63) days, or the shorter period of time as indicated in OHA's notice of Pharmacy Data Requiring Correction, OHA shall have the right to exercises its rights under Sec. 9, Par. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

14. Administrative Performance Standard

- a. OHA has implemented an Administrative Performance Standard to calculate a civil money penalty, the Administrative Performance Withholding (or AP Withhold), to be imposed on Contractor for its failure to meet the standards for submitting Pharmacy and Non-Pharmacy Encounter Data, to OHA and certified in accordance with Secs. 9-12 of this Ex. B, Part 8 (e.g. format, deadlines, methods of submission, accuracy) and OAR 410-141-3430 and that is also submitted to the All Payers All Claims database. However, if Contractor has met OHA's AP Standard, then Contractor and all other CCOs meeting the AP Standard will receive their

proportional share of the total AP Withhold amounts as set forth in this Section 13 of this Ex. B, Part 8.

- b.** OHA may provide further instructions about the AP Standard and AP Withhold calculation methodology. The Administrative Performance Standard and the imposition of an AP Withhold process will not alter OHA’s authority to: (i) administer the Encounter Data requirements of OAR 410-141-3430, or (ii) exercise any of its other rights and remedies, or other provisions under the Contract, or at law or in equity.
- c.** For purposes of determining whether a Contractor will be subject to an AP Withhold, the methodology set forth below will be followed:
- (1)** All Pharmacy and Non-Pharmacy Encounter Data for a Subject Month will be reviewed by OHA at the end of the Final Submission Month to determine whether Contractor submitted its Encounter Data in accordance with the AP Standard.
 - (2)** After review has been completed, OHA will send Contractor a Subject Month report within thirty (30) days after the end of the Final Submission Month.
 - (3)** If all of the Encounter Data provided by Contractor to OHA for the Subject Month meets the AP Standard, OHA will issue a Final Subject Month Encounter Data Report which shall be provided to Contractor’s Contract Administrator via Administrative Notice, and OHA will not impose an AP Withhold.
 - (4)** If the Final Monthly Encounter Data Report demonstrates that all of Contractor’s Encounter Data provided to OHA for the Subject Month did not meet the AP Standard, OHA will provide a Proposed SMED Report to Contractor’s Contract Administrator via Administrative Notice. The Proposed SMED Report will become the Final Monthly Encounter Data Report fifteen (15) days after the date of the proposed Subject Month report and OHA will calculate the AP Withhold amount based on such Final Monthly Encounter Data Report. However, if OHA receives a Legal Notice of appeal from Contractor for the applicable Subject Month in accordance with and subject to Sec. 8 of Ex. B, Part 9 of this Contract not later than fifteen (15) days after the date of the Proposed SMED Report, the Proposed SMED Report will not become final until after the conclusion of Contractor’s appeal. The Legal Notice of appeal from the Contractor, must include written support for the appeal.
 - (5)** If Contractor is subject to an AP Withhold pursuant to this Sec. 13, Ex. B, Part 8, after the: (i) conclusion of any appeal undertaken under Sub,Para. (4) above of this Para. c, Ex. B, Part 8, or (ii) expiration of time to request an appeal, OHA will provide Contractor’s Contract Administrator with Administrative Notice of the amount of the AP Withhold owing by Contractor. In general, OHA will set-off the AP Withhold amount for the applicable Subject Month from the following calendar month’s Capitation Payment.
- d.** 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 the eligible CCOs on the basis of Member Month Enrollment during the Subject Month. OHA will make AP pool distributions by separate Payment to the eligible CCOs promptly after all AP appeals related to the Subject Month have been resolved.

15. Drug Rebate Program

- a. Contractor acknowledges that OHA is eligible for ~~the~~ manufacturer rebates on any covered outpatient drugs provided by Contractor to Members as 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), section 1903(m)(2)(A)(xiii) ~~and~~ section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and OAR 410-141-3430(8).
- b. ~~Covered outpatient drugs dispensed to Members are subject to the same rebate requirements under section 1927, and~~ OHA will retain all ~~funds~~ rebates collected from such ~~rebates from~~ manufacturers, unless the drug is subject to discounts under Section 340B of the Public Health Service Act.
- c. In the event Contractor ~~shall report any rebates it~~ receives (either directly or ~~that its contracted PBM receives from Contractor's PBM) any rebates from a drug manufacturer to which OHA ~~d. is entitled.~~ Contractor shall ~~provide~~ report any and ~~require its subcontractors~~ all such rebates received. Such rebates shall be reported on Exhibit L Financial Report Template (See Sed. 1, Para. a., Sub. Para. (2) of Ex. L of this Contract).~~
- d. Contractor shall report to ~~provide~~ OHA sufficient data and information ~~for~~ to enable OHA to secure federal drug rebates for all utilization and administration of any covered outpatient ~~drug~~ drugs provided to Members. ~~e.~~ Such utilization information must include, at a minimum;
 - (1) Information on the total number of units of each dosage form, conversions, and strength and package size by National Drug Code of each covered outpatient drug ~~dispensed to Members;~~
 - (2) ~~The date of service (date of dispense) and actual claim paid date;~~
- f. ~~Contractor shall submit this NDC level information on drugs, biologics, and other Provider-administered products, including, but not limited to drug codes, units and conversions consistent with federal and Department requirements. dispensed to Members consistent with all Applicable Laws, including, without limitation, 42 Part 447 and OAR Chapter 410, Divisions 120 and 121; and~~
- g. ~~Contractor shall report prescription drug data within 45 days of the quarter in which the service was rendered, pursuant to 42 CFR 438.~~
 - (2) The Date of Service (date of dispense) and actual claim paid date.
- e. In addition to reporting Encounter Pharmacy Data to OHA in accordance with Secs. 10, 12 above of this Ex. B, Part 8 and this Sec.14, Ex. B, Part 8, Contractor ~~shall~~ must also report ~~to the OHA,~~ on a timely ~~and~~ periodic basis to OHA any other data as deemed necessary and as 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~~ of Health and Human Services.

~~16. Encounter Data Submissions~~ Drug Rebate Dispute Resolution Process

- a. 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~~ must assist OHA in the resolution process as follows:

- (1) ~~b.~~ Notify OHA's Encounter Data Liaison, via Administrative Notice, within fifteen (15) days of receipt of an Invoiced Rebate Dispute if Contractor agrees or disagrees; and
- (2) ~~e.~~ If the Contractor agrees with the Invoiced Rebate Dispute that an error has been made, Contractor ~~shall~~must correct and re-submit the Encounter Data to OHA, within forty-five (45) days of receipt of the Invoiced Rebate Dispute; or
- (3) If Contractor disagrees with the Invoiced Rebate Dispute that an error has been made, Contractor ~~shall~~must send the details of the disagreement to OHA's Encounter Data Liaison, within forty-five (45) days of receipt of the Invoiced Rebate Dispute.

17. Third Party Liability and Personal Injury Liens

- a. If a Member has other insurance coverage available for payment of Covered Services, such ~~resources are~~ other insurance is primary to the coverage provided by ~~the~~ Contractor under this Contract ~~and~~. Accordingly, the Other Primary Insurance must be exhausted prior to Contractor making any payment for ~~such any~~ Covered Services ~~by Contractor~~. If the Member has any liability for cost-sharing ~~incurred as part of such other coverage shall be paid to such insurer by Contractor~~.
- ~~b.~~ “Third Party Liability” mean any individual, entity, or program that is, or may be, liable to under the Other Primary Insurance, Contractor must pay all or part the amount of the medical Member’s cost of any medical assistance furnished to a Member sharing to the Other Primary Insurance.
- ~~b.~~ If Contractor recovers from a Third-Party Payer the fees Contractor shall paid for Covered Services provided to a Member, Contractor will have the right to retain those recoveries and Contractor must report to OHA per (11)(f) of this section. all amounts recovered from such Third-Party Payers. Reporting shall be made quarterly using the Exhibit L Financial Reporting Template.
- ~~c.~~ Contractor ~~shall~~must take all reasonable actions to pursue recovery of Third Party Liability for Covered Services provided ~~during the Contract period and up to 24 months to a Member. Contractor’s responsibility for recovery shall remain in effect up through the end of the eighteenth (18th) month from the date the claim(s) was paid date, at which point, OHA shall have the right to pursue recovery.~~
- ~~d.~~ ~~e.~~ After the end of the twenty-fourth (24th) month of the date any claim was paid by Contractor for which there remains Third Party Liability, OHA and/or its subcontractor(s) shall designee will take all reasonable actions to pursue recovery of such amounts from the applicable Third Party Liability for Covered Services not recovered by Payer. Contractor, beyond 24 months. Any recoveries by OHA will be reported and utilized in the Rate Development process must cooperate in good faith with OHA in any efforts undertaken by OHA to recover funds from Third Party Payers.
- ~~e.~~ ~~d.~~ Contractor ~~shall~~must develop and implement written policies ~~describing its and~~ procedures ~~for regarding~~ Third Party Liability recovery.
- ~~e.~~ Policies in a TPLR P&P Guidebook. The TPLR P&P Guidebook must include, at a minimum- must describe, all of the following:
 - (1) The requirement for ~~providers~~Providers and Subcontractors to request ~~Third Party Liability and obtain TPL~~ information from the ~~members~~Members and to promptly provide

such information to Contractor. At a minimum, the following information must be obtained and provided to OHA:

- (a) The name of the Third-Party Payer, or in cases where the Third Party Payer has insurance to cover the liability, the name of the policy holder;
 - (b) The Member's relationship to the Third-Party Payer or policy holder;
 - (c) The social security number of the Third-Party Payer or policy holder;
 - (d) The name and address of the Third-Party Payer or applicable insurance company;
 - (e) The policy holder's policy number for the insurance company; and
 - (f) The name and address of any Third-Party who injured the Member
- (2) The requirement of Contractor to report any and all TPL to OHA ~~within~~ the ~~specified timeframe when TPL is~~ timeframes identified in this Secs. 16 and 17 of this Ex. B, Part 8;
 - (3) The requirement of Contractor to pursue recovery for Covered Services, ~~and~~ and the procedures to be undertaken with such efforts;
 - (4) Policies related to record keeping of all recovery efforts undertaken, and recoveries obtained, and reporting of adjustments made to Encounter Data.
 - (5) Policies and procedures related to personal injury liens that comply with ORS 416.510 through 416.610, and OAR 461-195-0301 through 461-195-0350.
 - (6) ~~(4)~~ The requirement of Contractor to adjust ~~encounter claims~~ Encounter Data to reflect the amount received or recovered from the ~~primary payer~~ Third Party Payer;
 - (7) Any thresholds for determining whether to obtain a lien assignment; and
 - (8) A methodology for determining if and when it is no longer cost-effective for Contractor to pursue recovery of sums owing by a Third-Party Payer.
- f. Contractor must provide OHA, via Administrative Notice, its TPLR P&P Guidebook for review and approval, as set forth below in this Para. f, Sec. 16, Ex. B, Part 9, prior to its adoption and implementation as follows:
- (1) No later than January 31 of each Contract Year. In the event Contractor's TPLR P&P Guidebook has not been modified since it was last approved by OHA, Contractor may submit, along with the then-current unmodified TPLR P&P Guidebook, an attestation signed by Contractor's Chief Executive Officer, Chief Financial Officer, stating that no changes have been made to the TPLR P&P Guidebook since last approved by OHA. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website;
 - (2) Upon any material changes, including, without limitation, adopting a new TPLR policy with respect to any particular service, or modifying an existing TPLR Policy with respect to all or any services, regardless of whether OHA has provided approval of the TPLR P&P Guidebook prior to formal adoption of the policy; and
 - (3) As may be requested by OHA from time to time.
- g. ~~f. OHA will review Contractor's policies and procedures for~~ Review and approval of the TPLR P&P Guidebook will be based on compliance with this Contract and, to the extent OHA

determines applicable, for consistency with Third Party Liability recovery requirements as set forth in 42 USC 1396a (a)(25), 42 USC 1396k, 42 CFR Part 433 Subpart D, OAR 461-195-0301 to 461-195-0350, OAR 410-141-3080, and ORS 743B.470, 659.830, 416.510 to 416.610. ~~g. OHA will provide Contractor shall submit the policy as follows:~~ Contract Administrator with Administrative Notice of its approval or disapproval of Contractor's TPLR P&P Guidebook. In the event OHA does not approve Contractor's TPLR P&P Guidebook, Contractor shall follow the process set forth in Sec. 5 of Ex. D to this Contract.

h. Upon receipt of OHA's approval of Contractor's TPLR P&P Guidebook, Contractor must furnish such Policy to:

- ~~(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; All Members within thirty (30) days after receipt of OHA's annual written approval (i.e. after having been submitted on January 31 of each Contract Year);~~
- ~~(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; and~~
- ~~(4) Subject to OHA prior approval, Contractor shall furnish such information to:~~
 - ~~(a) Potential Members before and during Enrollment; and~~
 - ~~(b) All Members within 90 days after adopting the policy with respect to any particular service receipt of OHA's written approval any material changes to the TPLR P&P Guidebook.~~

i. h. If Contractor, or its ~~subcontractors or affiliated~~ Subcontractors, or its Affiliated entities have other lines of business related to third party insurance coverage such as Medicare Advantage or other individual or employer-sponsored plans, Contractor ~~shall arrange to~~ must compare its monthly ~~enrollment~~ Enrollment records with those records of its Subcontractors and its Affiliated entities to ensure that all Third Party Liability is identified. If any Member is also Enrolled with any of Contractor's Subcontractors or Affiliated entities, Contractor must document and promptly report any and all such matches to OHA within the timeframes specified in this section. thirty (30) days of the date of identification. Reporting must be made online at the following URL:
www.reporttpl.org

(1) Any information about PIP motor vehicle coverage should be reported to:
www.reportinjury.org

i. i. If Contractor receives information that a ~~member~~ Member has ~~coverage~~ Other Insurance outside of OHP ~~by a third party insurer~~, Contractor ~~agrees~~ must report such coverage to notify OHA, within thirty (30) days ~~and supply all requested coverage information via the online TPL reporting portal or by other format as prescribed by OHA, and require that its providers and subcontractors report to OHA when they become aware a member has other coverage. of Contractor's receipt of notice of the Other Primary Insurance. Reporting must be made online at the following URL:~~
<https://www.oregon.gov/DHS/BUSINESS-SERVICES/OPAR/Pages/tpl-hig.aspx>

- k. OHA may require Contractor to provide the information required to be reported under Paras. j. or k. or both, of this Sec. 16, Ex. B, Part 8, to be provided in another format. In such event, OHA will provide Contractor's Contract Administrator via Administrative Notice of such requirement and Contractor agrees it will promptly comply with all such requests.
- l. OHA reserves the right to require Contractor to make additional disclosures related to a Member's right to coverage by a Third Party Payer and Contractor agrees it will comply with all such requests that may be made from time to time.
- m. Contractor shall also require its Providers to:
- (1) Report to both Contractor and OHA any Other Insurance to which a Member may be entitled. Providers must report such information to OHA and Contractor within thirty (30) days of becoming aware Member of such coverage. Reporting must be made online at the URL identified above in Para. j. of this Sec. 16, Ex. B, Part 8; and
- ~~j.~~ ~~Failure to report TPL to OHA within the specified timeframe will result in a financial penalty equal to the monthly capitation amount received by Contractor for that member for each month the member was also enrolled in third party coverage.~~
- (2) Provide, in a timely manner upon request, OHA with all Third Party Liability eligibility information and any other information requested by OHA, in order to assist in the pursuit of financial recovery.
- n. ~~k.~~ ~~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. Contractor shall~~must ~~document and retain~~maintain, at the claim level, details related to, without limitation: (i) actions involving Third Party Liability; (ii) inability to recover any sums from Third Party Payers, and (iii) any and all recoveries from Third Party Liability to allow Payers. Such data must be documented in a manner that allows reconciliation and audit of reported recoveries and adjusted encounter claims data. Contractor must make such documents available to OHA or its designee(s), as may be requested from time to time.
- o. ~~l.~~ ~~Contractor shall report all Third Party Recoveries on Liability recoveries to the OHP Coordination of Benefits and Subrogation Recovery Section on the Quarterly Report~~quarterly report, Report L. 6 (sheet 6) of Exhibit L Financial Report Template (See Sec. 1, Para. a., Sub. Para. (2) of Ex. L).
- p. ~~m.~~ ~~Contractor retains all responsibility to~~must ~~adjust any encounter claims~~Encounter Data within the ~~timeframe~~timeframes ~~specified for encounter data adjustments~~under Secs. 9-12 above of this Ex. B, Part 8 to reflect Third Party ~~Recoveries for those claims.~~
- ~~n.~~ ~~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.~~Liability recoveries for such Encounter Data.
- q. ~~o.~~ ~~OHA will provide~~ Contractor ~~will receive from OHA~~with 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.
- r. ~~p.~~ Contractor agrees to: (i) provide ~~and require its subcontractors or affiliated entities to provide to~~ OHA with all Third Party Liability and eligibility information in order to assist in the pursuit

of financial recovery. ~~Contractor agrees to respond and require its subcontractors to~~ and (ii) respond in a timely manner to any other requests for information.

18. Personal Injury Lien

- ~~Contractor and its subcontractors must provide notification of all potentially liable third parties within 14 days to the Personal Injury Lien~~ The Personal Injury Liens Unit of OHA's the Office of Payment Accuracy and Recovery's (OPAR), ~~consistent with~~ of DHS is authorized pursuant to OAR 461-195-~~0301~~0303 to ~~461-195-0350~~administer the Personal Injury Lien program for OHA and DHS.
- When health care services or items have been provided to a Member and payment for such services or items have been made by the State under Medicaid, but a Third-Party nonetheless has the legal liability for such payments, the Member, pursuant to ORS 659.830(3) and 743B.470(3), is deemed to have automatically assigned to the State the right to such payment from the Third-Party.
- Contractor must inform the PIL Unit of DHS's OPAR of all third parties who are legally liable for all or part of the fees paid by Contractor for services provided to a Member. Contractor must inform PIL within thirty (30) days of learning of such potential liability, and such information must be made in accordance with OAR 461-195-0301 through 461-195-0350.
- (1) Contractor shall inform PIL of such potential liability using the PIL secure web portal located at the following URL:
www.reportinjury.org
- (2) After completing its report, Contractor is encouraged to print and maintain a copy of such report in its files.
- In no event shall Contractor request or require a Member to execute a trust agreement or loan receipt or other similar arrangement to guarantee reimbursement of Contractor.
- ~~b.~~ Contractor must receiveobtain a written lien assignment from OHA or its designee prior to any attempt to seek reimbursement from the recipient's a Member's, or a Member's beneficiary's, proceeds arising from an injury or death caused byfor which a third party, and must notify OHA within 14 days once is financially legally liable. Contractor must, in accordance with ORS 416.540 through 416.560, perfect the lien and provide notice to all parties that are subject to the lien. Contractor must then provide PIL with Administrative Notice that a lien has been filed. Such Administrative Notice must occur within ten (10) days after the lien has been perfected. Contractor agreeshas no authority to provide to OHA sell or designee a list of all active PIL cases upon request otherwise transfer its rights in the assigned lien.
- Contractor shall request a lien assignment by completing the online request located at the following URL: www.reportinjury.org. At a minimum, Contractor shall provide the following information, if known, when requesting a lien assignment:
- (1) Contractors name
- (2) Member's name and address
- (3) Date of injury to the Member

- (4) Insurance or Attorney information for either the Member or liable party
- (5) Under comments of the online form, indicate “Request Lien Assignment”
- g.** Within five (5) Business Days after the end of each calendar month, Contractor shall provide the PIL Unit with a report of a list of all active PIL cases and a list of all PIL cases closed or terminated in a format identified by the PIL Unit. Such monthly report shall include the following information: .
- (1) Contractor’s name;
- (2) All active liens/PIL cases;
- (3) All liens that were closed or terminated in the subject month;
- (4) For all cases, all of the following information:
- (a) The Member’s name and Medicaid ID number;
- (b) The date of the Member’s injury;
- (c) The amount of Contractor’s lien;
- (5) For all closed or terminated liens:
- i. the date of any settlement or judgment, if known;
- ii. The gross amount of any settlement or judgment, if known;
- iii. The amount received from any liable third-party, and
- (6) Any other information that PIL may request.
- h.** ~~e.~~ Contractor must ~~submit~~create a copy of its lien release for review and approval to OHA by 31 January of each year, and at any time there is a material change to the document. The lien resolution must clearly state that Contractor has Lien Release Template which shall be used when its Members may be entitled to seek recovery from third-parties who are potentially legally liable for all or part of the services provided to a Member and paid for by Contractor. . The Lien Release Template must conform with the requirements of ORS 416.560, and, notwithstanding the authority to resolve ~~liens assigned to them and does not have~~a lien, Contractor has no other the authority to act on behalf of the ~~state~~State beyond the assigned lien.
- ~~d.~~ Contractor must notify the Personal Injury Lien Unit of the resolution of any liens within 30 days, and include the following information:
- (1) ~~The amount of lien asserted~~
- (2) ~~The amount received for the release of the lien.~~
- (3) ~~The settlement amount received by enrollee.~~
- i.** Contractor must provide its Lien Release Template to PIL annually for review and approval prior to use . The Lien Release Template shall be provided to the PIL Unit via Administrative Notice to to OHA by no later than January 31 of each Contract Year. Review and approval will be provided by PIL via Administrative Notice to Contractor’s Contract Administrator within thirty (30) days of receipt. In the event OHA disapproves of the Lien Release Template for failure to comply with this Contract or Applicable Law or (or both), Contractor shall, in order to remedy the deficiencies in such Template, follow the process set forth in Sec. 5, Ex. D of this Contract.

- j.** In the event Contractor makes a material change to the Lien Release Template after it has been approved by the PIL Unit, Contractor must provide such amended Template to the PIL Unit via Administrative Notice to OHA for review and approval. Review, approval, and any remediation if the amended Template is disapproved, shall be made by Contractor in accordance with Para. d. above of this Sec. 17, Ex. B, Part 8.
- k.** ~~e.~~ Contractor ~~may~~does not ~~have the right to~~ refuse to provide Covered Services and ~~shall require that must not permit any of~~ its Participating ~~Provider may not~~Providers to refuse to provide Covered Services; to a Member because of ~~a~~potential Third Party ~~potential liability~~Liability for payment for the Covered Service.
- l.** Contractor must obtain the prior written approval of the PIL Unit before compromising any assigned lien. In the event both Contractor and OHA have a lien against the same third-party, the lien filed by the PIL Unit is payable before Contractor's lien.
- m.** If the PIL Unit has a lien that has not been paid in full, and Contractor has received payment on such lien, OHA shall have the right to set-off from Payments owing to Contractor the lesser of (i) the unpaid amount of the PIL lien, or (ii) the amount that Contractor received in satisfaction of such lien. The PIL Unit shall have the right to request, and Contractor shall promptly provide after the PIL Unit has so requested, access to Contractor's closed or resolved case files to determine if the PIL liens were paid in full.
- n.** If a Member fails to cooperate with Contractor as required under OAR 461-195-0303, Contractor shall notify OHA, via Administrative Notice, within ten (10) days of learning of such Member's failure to cooperate.
- o.** Prior to commencing any litigation related to an assigned lien, Contractor must first obtain prior written approval from the PIL Unit. Contractor shall promptly reassign the lien to OHA upon request by OHA.
- p.** ~~f.~~ If a ~~claim advances to~~Member or a third-party initiates litigation ~~that has been previously assigned~~related to Contractor's assigned lien, Contractor will promptly provide ~~notification to OHA within 10 days of initiating the action and include the information specified in OAR 461-195-0310.~~Administrative Notice (but in no event more than ten days after learning of such initiation) the PIL Unit. Such Administrative Notice shall be made via email to the following address: personal.injury@state.or.us. Contractor agrees to promptly reassign the lien to OHA upon request.
- (1)** In the event a lien is reassigned to the PIL Unit, Contractor shall cooperate therewith by providing all documentation and information requested by the PIL Unit, making witnesses available, and providing any other assistance that may be required to resolve any lien.
- (2)** Contractor shall permit the PIL Unit to communicate and work directly with any Subcontractor in order to efficiently undertake and manage any TPL activity.
- (3)** Contractor and Contractor's Subcontractors shall enter into any data sharing agreements with the PIL Unit or OHA, or both, as may be requested thereby.
- q.** ~~g.~~ 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~~Disenroll a

Member to the time the Member acquired ~~Third Party Liability insurance~~the Other Primary Insurance, pursuant to OAR 410-141-3080(3)(e)(~~BA~~) or 410-141-3080(9)(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~~Disenrolled under this ~~section~~Para. g, Sec. 17, Ex. B, Part 8 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 do not seek~~have the right to collect, ~~and shall not attempt to collect~~, from a Member (or any financially responsible Member Representative) or any Third ~~Party~~ Liability Payer, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

- ~~r.~~ h. Contractor shall comply with 42 USC §1395y(b) and 42 CFR Part 411, Subparts C-E, 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.
- ~~s.~~ i. Where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability Payer is not sufficient to ~~satisfy the claims of~~fully reimburse both programs ~~to reimbursement for their respective claims~~, the Third Party Liability Payer must first reimburse Medicare the full amount of its claim before any other entity, including Contractor or its Subcontractors, may be paid.
- ~~t.~~ j. If the Third Party Payer has reimbursed Contractor, or its Participating Providers, or Subcontractors, ~~or if then the parties who received such reimbursements must, if Medicare is unable to recover its payment from any remaining amounts payable by the Third Party Payer, reimburse Medicare up to the full amount received from the Third Party Payer.~~
- ~~u.~~ l. If a Member, after receiving payment from the Third Party Liability Payer, has reimbursed Contractor, or its Subcontractors, or Participating Providers, ~~then the Contractor or its Subcontractors or Participating Providers must reimburse Medicare up to the full amount the Contractor or Subcontractors or Participating Providers parties who received such reimbursements must, if Medicare is unable to recover its payment from the remainder of any remaining amounts payable by the Third Party Liability payment Payer, reimburse Medicare up to the full amount received from the Member.~~
- ~~v.~~ k. ~~Any such Medicare reimbursements described in this section are the Contractor's responsibility on presentation of appropriate~~Contractor must reimburse a Medicare carrier for any payments made that were otherwise paid by Third Party Payers. Reimbursement must be made to the Medicare carrier promptly upon request by Medicare and presentment of supporting documentation from the Medicare carrier. Contractor shall document such Medicare reimbursements in its reportExhibit L Quarterly Financial Report submitted to OHA.
- ~~w.~~ l. When engaging in Third Party Liability recovery actions, Contractor shall comply with, and require ~~its Subcontractors or~~ agents to comply with, the federal and State confidentiality requirements; described in Exhibit Sec. 6, Ex. E of this Contract and any other additional confidentiality obligations required under this Contract and State law. Contractor agrees to comply ~~and require its Subcontractors to comply~~ with ORS 416.510 through 416.610 when enforcing an assigned lien. OHA considers the disclosure of Member claims information made in connection with Contractor's ~~TPR recovery~~Third Party Recovery actions a purpose that is directly connected with the administration of the Medicaid program.

19. Disclosure of Ownership ~~Interest~~ Interests

- a. Contractor ~~shall~~ must provide OHA with the disclosures required in this Sec. 18, Ex. B, Part 8 at the time Contractor executes this Contract in accordance with the details set forth in Paras. b-c below of this Sec. 18, Ex. B, Part 8. The disclosures under this Sec. 18 -19, Ex. B, Part 8 are subject to 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. Disclosures will be reviewed by OHA in accordance with 42 CFR §§438.602(c) and 438.608(c). Such disclosures shall include the following: ~~and OAR 410-120-1260 and required to be made to OHA by Contractor and if requested, furnished to CMS and.~~

~~(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:~~

- b. Contractor must provide all of the following information to OHA in writing:

~~(1) (a) Name~~ The name and address (the address for corporate every Person with an Ownership or Control Interest in Contractor. Any and all entities must include as applicable primary business address, every the address for (i) each of its business location, and locations, (ii) any P.O. Box address that it uses, and (iii) its primary business address.)

~~(2) (b) Date of birth and Social Security Number (in the case of an for every individual)~~ disclosed under Sub. Para. (1) above of this Sec. 19, Ex. B, Part 8.

~~(c) Other~~

~~(3) The FEIN or other tax identification number (in the case of a corporation)-~~

~~(d) The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest for every entity disclosed under Sub. Para.(1) above of this Para. a, Sec.18, Ex. B, Part 8.~~

~~(4) For each Person with an Ownership or Control Interest, that equals or exceeds 5%, in Contractor's Subcontractors, service providers, or suppliers, the social security number (for an individual), FEIN or other tax identification number (for entities).~~

~~(5) Identify any and all Persons disclosed under Sub-Para.(1) above, of this Sec.18, Ex. B, Part 8 who are related to one another and disclose the relationship between and among such Persons. For individuals related to one another, indicate whether they are a parent (including step-parents), spouse, in-law, child, or sibling (including step- and half-siblings) and for entities that are Affiliates, indicate how the entities are Affiliated (e.g., parent company, subsidiary, or other type of Affiliation).~~

~~(6) Identify any and all Persons disclosed under Sub.Para.(4) above, of this Sec.18, Ex. B, Part 8 who are related to one another and disclose the relationship between and among such Persons. For individuals related to one another, indicate whether they are a parent (including step-parents), spouse, in-law, child, or sibling (including step- and half-siblings) and for entities that are Affiliates, indicate how the entities are Affiliated (e.g., parent company, subsidiary, or other type of Affiliation).~~

- ~~(7)~~ ~~(e)~~ The name, address, date of birth, and ~~Social Security Number of any managing employee of the Contractor~~social security number of Contractor's Managing Employee(s).
- ~~(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 of 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.~~
- ~~(8)~~ ~~(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~~Identify any and all Persons disclosed under Sub-Paras.(1), (4), and (7) above of this Sec. 18, Ex. B, Part 8 and any Agent of Contractor who have been convicted of a criminal offense related to that ~~person~~Person's involvement in any program under Medicare, Medicaid, or other federal services program since ~~the~~the 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:~~
- ~~(9)~~ The name(s) of any Other Disclosing Entity, or other CCO in which the Persons disclosed under Sub-Para. (1) above, of this Para. a, Sec. 18, Ex. B, Part 8 have an Ownership or Control Interest.
- ~~c.~~ The disclosures required to be made under Paras. a and b above of this Sec.18, Ex. B, Part 8 must be provided to OHA by Contractor at all of the following times and by the following means:
- ~~(1)~~ ~~Within at least 90 days prior to any changes in ownership or controlling interest of 5 percent or more;~~Upon Contractor's submission of Contractor's Application: As provided for in the RFA,
- ~~(2)~~ ~~Upon request of OHA during re-evaluation of Enrollment processes under 42 CFR §455.414;~~Upon Contractor's execution of this Contract: Via Administrative Notice to OHA,
- ~~(3)~~ ~~Within 35 days after any change in ownership, with equity shares transferred being less than 50%;~~Upon amendment, renewal, or extension of this Contract: Via Administrative Notice to OHA,
- ~~(4)~~ ~~When Contractor executes a contract with OHA; and~~Subject to Sec. 20 below of this Ex. B, Part 8, within thirty-five (35) days after there is a change in any Person with an Ownership or Control Interest in Contractor: Via Administrative Notice to OHA, and
- ~~(5)~~ ~~When Contractor amends the contract with OHA through renewal or extension.~~Upon request by OHA during the re-validation of enrollment process as set forth in 42 CFR §§455.104 and 455.414. Requests made under this Sub-Para. (5), Para. c, Sec.18, Ex. B, Part 8 will be made as directed by OHA in its request.
- ~~d.~~ Contractor must provide OHA with Administrative Notice of any of the following: (i) any change of address (e.g. primary, P.O. Box, business location, home), (ii) a change of Federal Tax Identification Number, and (iii) as applicable, any change in licensure status as a health plan

with Department of Consumer and Business Services, or as a Medicare Advantage plan. Such Administrative Notice must be made within fourteen (14) days after the applicable change and must identify the new address or TIN (or both) and the date upon which such change(s) became effective.

20. ~~Upon renewal or extension of the Contract~~ Disclosure of Other Ownership Interests

In addition to the disclosures Contractor is required to make under Sec. 18 above of this Ex. B, Part 8, Contractor must also make all of the disclosures required under this Sec.19, Ex. B, Part 8:

a. Upon written request by OHA, which will be made via Administrative Notice to Contractor's Contract Administrator, Contractor must disclose:

(1) The name, phone number, and address of any and all Persons with an Ownership or Control Interest in a Subcontractor, service provider, or supplier with whom the Contractor has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of request; and

(2) The name, phone number, and address of any Wholly Owned Supplier with whom Contractor has had any Significant Business Transactions during the five (5) year period ending on the date of request.

b. As provided for under 42 CFR §455.105(a), the Secretary of Health and Human Services or any authorized officer or employee thereof has the right to request, and Contractor must provide, thereto, the disclosures identified in this Sec. 19, Ex. B, Part 8.

c. Disclosures required to be made under this Sec. 19, Ex. B, Part 8 must be made in writing by Contractor within thirty-five (35) days of the date of request by OHA or HHS as applicable, and provided thereto in the manner requested by, as applicable, OHA or HHS.

21. Certain Changes in Ownership Requiring Pre-Approval from OHA

Change in ownership is consolidation or merger of Contractor, or of a corporation or other entity or person ~~controlling~~ Controlling or ~~controlled~~ 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~~ 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~~ Controlling or Controlled by Contractor, in a transaction or series of related transactions as specified in 42 CFR §455.104(c)(3).

a. Contractor shall ~~notify~~ provide OHA Legal Notice, in accordance with Sec. 26, Para. a., Exhibit D of this Contract, at least 90 days prior to any change in ownership ~~and~~ Contractor shall 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~~ provide Administrative Notice, in accordance with Sec. 26, Para. b. Exhibit D of this Contract. to OHA's Contract Administrator of any changes of address, and as applicable licensure status as a health plan with ~~DCBS~~ Department of Consumer and Business Services or as a Medicare Advantage plan, or Federal Tax Identification Number ~~(TIN)~~, within fourteen (14) days of the change.

- c. Failure to notify OHA of any of the above changes may result in the imposition of a ~~sanction~~Sanction from OHA and may require Corrective Action to correct ~~payment~~Payment records, as well as any other action required to correctly identify ~~payments~~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~~Subcontract, reassignment or sale occurs, except as otherwise provided in ~~Exhibit Ex. B, Part 4, Section 11~~Sec. 14 of this Contract governing adjustments in Service Area or Enrollment and ~~Exhibit Ex. D, Section 18~~"Subcontracts" Sec. 20.
- 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 5% or more of the proposed new Entity's equity ("Entity" is defined under OAR 410-141-3000. Any entity that is proposed by Contractor to assume this Contract is referred to herein as the "New Entity";);
 - (2) Representation and warranty signed and dated by both the proposed ~~new~~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 and if required, approved by 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 by the New Entity once OHA has approved the ownership change request, except as modified by ongoing Contract and Administrative Rule requirements. If Contractor and the proposed ~~new~~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~~New Entity for review consistent with the requirements of this Contract;
 - (3) The financial responsibility and solvency information for the proposed ~~new~~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~~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~~New Entity may be certified to perform all of the obligations under this Contract and that the ~~new entity~~New Entity meets the financial solvency requirements and insurance requirements to assume this Contract.

22. ~~20.~~ 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~~any entity or individual that directly or indirectly receives funds under this Contract, including, but not limited to any health care provider, manufacturer, wholesale or retail suppliers, sales representatives, ~~testing~~distributor, laboratories, or any other Providers~~provider~~ in the design, manufacture, ~~Marketing~~marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, ~~DMEPOS~~durable medical equipment, or other health care related products. Nothing in this provision prevents the State of Oregon from working with the Contractor ~~and releasing~~to release its right to subrogation in a particular case.

23. ~~21.~~ Contractor's Governing Board of Directors

Contractor shall ~~promptly notify~~provide OHA's Contractor with Administrative Notice of any change in membership in Contractor's ~~board of directors~~Governing Board. Such ~~notice~~Administrative Notice shall be provided ~~within~~promptly but in no event more than thirty (30) days ~~of~~after any such change.

[Remainder of page intentionally left blank]

Exhibit B—Statement of Work - Part 9—

Program Integrity

1. Monitoring and Compliance Review - Overview

- a. OHA is responsible for ~~monitoring compliance~~Monitoring Contractor's compliance with the ~~requirements in terms and conditions of~~ this Contract and all Applicable Laws related thereto. Methods of ~~monitoring~~ensuring compliance may include any or all of the following: (i) review of documentation submitted by Contractor, (ii) Contract performance review, (iii) review of Grievances, (iv) review of reports generated by the EQRO, (v) on-site review of ~~documentation or documents and~~ any other source of relevant information, ~~including Contractor and Subcontractor information and cooperation required under Exhibit B, Part 8. Contractor agrees to cooperate and require its Subcontractors to cooperate to make any and all records and facilities available for compliance review.~~
- b. If, after conducting an audit or other compliance review, Contractor's compliance cannot be determined, or if OHA determines that Contractor ~~is non-compliant with the requirements~~has breached the terms or conditions (or both) of the this Contract, OHA ~~may find Contractor has breached Contract requirements and may impose Liquidated Damages, financial penalties or Sanctions and pursue any other remedies available under this Contract~~will have the right to impose Sanctions, including civil money penalties.
- c. OHA will ~~monitor~~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.
- ~~d. Upon identification of performance issues, deficiencies, indications that quality, access or cost-containment goals are being compromised, or that circumstances exist that affect Member rights or health, OHA will promptly intervene within 30 days of identifying a concern to remediate the identified issue(s) and require Contractor to develop and implement a Corrective Action Plan (CAP).~~
- ~~d. If~~Upon identification of Performance Issues, Contractor ~~fails~~will be deemed to ~~remedy the deficiencies, or fails to improve performance within the specified timeframe, the state~~be in breach of this Contract. In such event, OHA will have the right to impose Sanctions, which may requireinclude requiring Contractor to develop and implement a Corrective Action Plan. ~~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.—~~as set forth in additional detail below in this Ex. B, Part 9 of the Contract.
- e. Nothing in this Contract precludes OHA from pursuing more than one remedy or Sanction for a breach by Contractor. OHA's will have the right to pursue any and all remedies available to it under this Contract and at law or in equity. OHA's remedies are cumulative to the extent they are not inconsistent and OHA will have the right to pursue, in addition to the imposition of Sanctions, any remedy or remedies singly, collectively, successively, or in any order whatsoever.

2. Conditions that may Result in Sanctions

- a. OHA ~~may~~will have the right to impose Sanctions if it determines, based on: (i) any audits (on- or off-site), (ii) review of Contractor Encounter Data, or (iii) its exercise of any of its other rights under this Contract, that Contractor has acted or failed to act as described in this ~~Section or Sec.~~

~~2, Ex. B, Part 9, or failed to comply with~~ any of the other provision terms or conditions 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.~~

b. ~~Conditions that may result in a Sanction under~~Without limiting Para. a above, of this section may include Sec. 2, Ex. B, Part 9, OHA shall have the right, pursuant to 42 CFR §438.700, to impose Sanctions when Contractor ~~acts or fails to act~~breaches this Contract as follows:

- (1) Fails to authorize or otherwise substantially ~~to~~ provide Medically Appropriate services that the Contractor is required to authorize and provide, ~~under law or under its Contract with OHA~~, to a Member ~~covered~~in accordance with applicable State or federal law or as required under this Contract;
- (2) Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under ~~the Medical Assistance Program~~this Contract or applicable State or federal law;
- (3) Acts to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, ~~or~~ disability, ~~their~~ health status, ~~or their~~ need for health care services. ~~This includes~~ Acts that may be evidence of discrimination include, but ~~is~~are not limited to, ~~termination~~: (i) Disenrollment of ~~Enrollment~~, or refusal to reenroll, a Member, except as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or ~~seek the disenrollment~~(iii) any practice that seeks or encourages the Disenrollment of individuals whose protected class, medical condition or history indicates probable need for substantial future ~~medical services~~Medical Services;
- (4) Misrepresents or falsifies any information that ~~it furnishes~~is required to be submitted to CMS ~~or to~~, the State, or ~~its~~their designees under this Contract, including but not limited to ~~the assurances~~any such information submitted in: (i) or in connection with its application or Enrollment, Contractor's Application, or enrollment with CMS, (ii) any certification, made in connection with this Contract, (iii) any report required to be submitted under this Contract, encounter data or (iv) any other information documentation or other communication provided to the State, CMS, or their designees relating to the care or services provided to a Member or as otherwise required to be made under this Contract;
- (5) Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider;
- (6) Fails to comply with the requirements for Physician Incentive Plans, as the requirements are set forth in 42 CFR §422.208 and §422.210; and this Contract;
- (7) Fails to comply with the operational and financial accounting and reporting requirements ~~specified in~~required under Ex. L of this Contract;
- (8) Fails to maintain a Participating Provider Panel sufficient to ensure adequate capacity to provide Covered Services to its Members under this Contract;
- (9) Fails to implement and maintain an internal Quality Improvement program, ~~or a~~ Fraud, Waste and Abuse prevention program, a Quality Assurance and Performance Improvement Program, or to provide timely reports and data in connection with the such programs as required under this Contract;

- ~~(10) Fails to maintain an internal QA/PI program;~~
- (10) ~~(11)~~ Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, ~~and record~~or record keeping and reporting requirements;
- (11) ~~(12)~~ Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this Contract;
- ~~(13) Fails to follow accounting principles or accounting standards or cost principles required by federal or State laws, rule or regulation, or this Contract;~~
- (12) ~~(14)~~ Fails to make timely claims ~~payment~~payments to Providers or fails to provide timely approval of authorization requests;
- (13) ~~(15)~~ Fails to disclose required ownership information or fails to supply requested information to OHA ~~on relating to Contractor's~~ Subcontractors ~~and or~~ suppliers of goods and services;
- (14) ~~(16)~~ Fails to submit accurate, complete, and truthful ~~encounter data~~Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by ~~Exhibit Ex.~~ B, Part 8, ~~Section 7~~;
- ~~(17) Fails to submit accurate, complete and truthful Pharmacy Data in the time and manner required by Exhibit B, Part 8, Section 9; or~~
- (15) ~~(18)~~ Distributes directly or indirectly through any agent or independent contractor, Marketing ~~materials~~Materials that have not been approved by the State or that contain false or materially misleading information;
- ~~(19) 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;~~
- (16) ~~(20)~~ Violates any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or
- (17) ~~(21)~~ Violates any of the other applicable requirements of 42 USC §1396b(m) or §1396u-2 and any implementing regulations.

3. Range of Sanctions Available

- a. ~~The use of one sanction by OHA does not preclude the imposition of~~In the event Contractor is in breach of this Contract, OHA will have the right to impose one or more Sanctions or any other sanction or combination of Sanctions ~~or any other remedy authorized under this Contract~~ for the same ~~deficiencies. OHA may~~breach. For illustrative purposes only, OHA will have the right, whether Contractor has breached the Contract once or has engaged in a pattern of severe, repeated misconduct in breach of this Contract, to impose a ~~sanction~~civil money penalty, while also requiring ~~the development~~Contractor to develop and ~~implementation~~implement of a ~~Corrective Action Plan if the deficiencies are severe or numerous~~CAP, and obtain additional insurance.
- b. Pursuant to 42 CFR §438.702 et seq., OHA may impose one or more of any of the following Sanctions:

- (1) Civil money penalties.
- (2) Appointment of temporary management.
- (3) Granting Members the right to Disenroll without cause and notifying the affected Members of their right to Disenroll.
- (4) Suspension of all new Enrollment, including automatic Enrollment.
- (5) Suspension of Payments for Members Enrolled after the effective date of the Sanction until such time that CMS or OHA is satisfied that the reason for the imposition of Sanctions ~~no longer exists and is not likely to recur.~~
- (6) Denial of 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
- (7) Other Sanctions as permitted under OAR 141-410-3259(h), which may include, without limitation:
 - (a) Assessment of a recovery amount equal to one percent (1%) of Contractor's last total monthly Capitation Payment immediately prior to imposition of the Sanction. Such amount will be set-off from Contractor's next total monthly Capitation Payment;
 - (b) Require Contractor to develop and implement a CAP that is acceptable to OHA for correcting the problem;
 - (c) Where financial solvency is involved, actions may include increased reinsurance requirements, increased reserve requirements, market conduct constraints, or financial examinations; or
 - (d) Civil money penalties in addition to those identified in 42 CFR §438.704.

4. Amount of Civil Money Penalties: 42 CFR §438.704

~~b.~~ OHA may ~~assess financial~~impose civil money penalties in the amounts authorized in 42 CFR §438.704. ~~If OHA imposes financial penalties as provided under 42 CFR 438.702(a)(1), the maximum penalty varies depending on the nature of the infraction as follows.~~

a. ~~e.~~ The limit is \$25,000 for each determination where OHA finds Contractor has done any of the following:

- (1) Failed ~~to authorize or to otherwise~~ substantially ~~to~~ provide Medically Appropriate services to a Member that the Contractor is required to provide; ~~under law or under its Contract with OHA, to a Member covered under this Contract; or applicable State or federal law.~~
- (2) ~~Misrepresented or falsified any information that it furnished 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;~~ Misrepresents or falsifies any information that it furnishes to a Member, potential Member, or Provider.
- (3) Failed to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR §§ 422.208 and 422.210, and this Contract; ~~or.~~

- (4) Distributed directly or indirectly through any Subcontractor, agent, or independent contractor, Marketing ~~materials~~Materials that ~~have~~were not ~~been~~ approved by the State or that ~~contain~~contained false or materially misleading information:
- ~~b.~~ d. The limit is \$100,000 for each determination where OHA finds Contractor has:
- (1) Acted to discriminate among Members on the basis of their protected class such as race, ethnicity, national origin, religion, sex, sexual orientation, marital status, age, or disability, their health status, or their need for health care services. ~~This includes Evidence of discrimination may include~~, but is not limited to, ~~termination of Enrollment~~Disenrollment for 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~~Medical Services; or
- (2) Misrepresented or falsified any information that ~~it is~~ furnished to CMS or to the State or their designees under this Contract, including but not limited to, such information included in: (i) Contractor's Application, (ii) any certification, (iii) any report, or (iv) other documentation or communication relating to the care or services provided to a Member.
- c. ~~e.~~ The limit is \$15,000 for each Member OHA determines was not ~~enrolled~~Enrolled on the basis of their health status or their need for health care services; subject to an overall maximum of \$100,000 as set forth in Para.c, Sub-Para.(1) above of this Sec. 4, Ex. B, Part 9.
- ~~f.~~ In addition to the specific penalties identified in Section 3, OHA may:
- (1) ~~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 the sanction;~~
- (2) ~~Grant Members the right to disenroll without cause (OHA may notify the affected Members of their right to disenroll);~~
- (3) ~~Suspend all new Enrollment, including Enrollment from auto-assignment, or transfer any of Contractor's enrolled Members after the effective date of the sanction;~~
- (4) ~~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;~~
- (5) ~~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;~~
- (6) ~~Require Contractor to develop and implement a Corrective Action Plan that is acceptable to OHA for correcting the problem;~~
- (7) ~~Where financial solvency is involved, actions may include increased reinsurance requirements, increased reserve requirements, market conduct constraints, or financial examinations; and~~
- (8) ~~Impose any other Sanctions, in accordance with 42 CFR §438.702, reasonably designed to remedy or compel future compliance with this Contract.~~

- d. In the event Contractor imposes premiums or charges in excess of the amounts imposed under the Medicaid program, the maximum amount OHA will impose is the greater of \$25,000 or double the amount of the excess premium or charge. Promptly after collection of the sums permitted under this Para. e, Sec. 4, Ex. B, Part 9, OHA will deduct therefrom the amount of the excess charge or premium and return it to the affected Member(s).

5. Temporary Management.

- a. ~~g.~~ If in accordance with 42 CFR §438.706 (a) if OHA determines, as a result of onsite surveys, receipt of Member or other complaints, review of Contractor's financial status, or through any other source, that (i) there is continued egregious behavior or, (ii) Contractor has engaged in any conduct described in 42 CFR §700 or is contrary to the requirements of sections 1903(m) or 1932 of the Social Security Act, or (iii) that there is substantial risk to Members' welfare, or that action is necessary to ensure the health of Members while (but for this subsection (iii) the outside management will be required for only so long as improvements are being made to remedy violations or until there is an orderly termination or reorganization by Contractor: ~~(1)~~ OHA must shall have the right, in its discretion, to require Contractor, at its own cost and expense, to implement temporary management mechanisms, such as employment of consultants or other individuals or entities approved by OHA at Contractor's expense;
- b. ~~(2)~~ OHA must In accordance with 42 CFR §438.706(b) OHA will require Contractor, at its own cost and expense to impose temporary management mechanisms, such as employment of consultants or other individuals or entities approved by OHA, if OHA determines that Contractor has failed to: (i) meet the substantive requirements of sections 1903(m) or 1932 of the Social Security Act or (ii) comply with any Sanction imposed under this Contract. Notwithstanding the imposition of temporary management, OHA will also grant Members the right to disenroll Disenroll without cause and notify Members of the their right to disenroll Disenroll without cause;
- c. ~~(3)~~ OHA must will not delay the imposition of temporary management mechanisms to provide for Administrative Review before imposing this sanction Sanction; and
- d. ~~(4)~~ OHA must will not terminate temporary management mechanisms until it determines that Contractor can ensure that the sanctioned behavior will conduct that resulted in a breach or repeated breaches of this Contract will not reoccur reoccur.

6. 4-Corrective Action Plan

- a. If OHA determines that Contractor's breach of this Contract requires Contractor to develop and implement a ~~Corrective Action Plan CAP~~, the ~~Corrective Action Plan must CAP shall~~ include, at a minimum, all of the following:
- (1) A description of the issues and factors which contributed to ~~the deficiency~~ Contractor's breach;
 - (2) Designation of ~~a one~~ person within Contractor's organization who is charged with the responsibility of correcting the issue being responsible for ensuring the CAP is implemented and the conduct that resulted in a breach or repeated breaches of this Contract do not reoccur;
 - (3) A detailed description of the specific actions Contractor will take to remedy ~~the deficiency~~ its breach of this Contract;

- (4) A timeline ~~for when those actions will begin and when the deficiency will be corrected;~~that identifies when Contractor must begin implementing such specific actions and a date certain by which Contractor must have fully remedied its breach or put in place the necessary mechanisms to prevent a reoccurrence of the same or similar breach. In all instances, CAPs must be completed within one hundred and eighty (180) days from the date of implementation of the CAP;
- (5) Identification of any ~~member~~Member access to care issues that were caused as a result of the ~~deficiency~~breach; and
- (6) If the ~~deficiency originated with~~breach was a result of a Subcontractor's failure to comply with the terms and conditions of this Contract, a description of ~~how~~the activities, processes, and evaluation criteria Contractor intends ~~to monitor~~undertake for the purpose of Monitoring Subcontractor performance and compliance to prevent reoccurrence;
- ~~(7) A timeframe no less than 180 days from the projected correction date when Contractor shall provide a status update to OHA to demonstrate that the actions taken to remedy the deficiency have effectively corrected the issue.~~
- ~~b. If Contractor fails to submit 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.~~

~~5. Liquidated Damages~~

- ~~a. Contractor acknowledges that any failure to meet the responsibilities or specific performance standards for deliverables to OHA outlined in the Contract results in damages to OHA in the form of additional work on the part of OHA staff, failure to meet internal deadlines, or unanticipated project delays.~~
- ~~b. The liquidated damages prescribed in this section are intended to be reasonable estimates of projected financial loss and damage resulting from the Contractor's nonperformance of specific contract requirements. In the event of Contractor's failure to perform in accordance with this Contract, OHA may assess liquidated damages as provided in this section. Contractor shall be required to provide OHA with, as directed by OHA, a written status update evidencing that the CAP has been completed and that the breach or breaches or the conduct that resulted in the breach(es), deficiency or deficiencies have been fully and successfully remedied. OHA shall also have the right to request, and Contractor shall be required to provide, periodic status reports during the period a CAP is being performed.~~
- ~~c. If the Contractor fails to perform any of the services described in the Contract, OHA may assess liquidated damages for each occurrence listed in the table below. Any liquidated damages assessed by OHA shall be due and payable within thirty (30) days after Contractor receives notice of the assessed damages, regardless of any dispute in the amount or interpretation which led to the notice. All CAPs shall be provided to OHA via Administrative Notice for review and approval within the time frame identified by OHA. OHA will provide, via Administrative Notice to Contractor's Contract Administrator, approval or disapproval of the proposed CAP. In the event OHA disapproves of a CAP, Contractor shall, in order to remedy the deficiencies in such CAP, follow the process set forth in Sec. 5, Ex. D of this Contract.~~

- ~~d. The decision to assess liquidated damages does not prohibit OHA from imposing any other financial penalty or Sanction.~~
- ~~e. If liquidated damages are assessed, OHA may elect to collect:
 - ~~(1) Through direct assessment and request for payment delivered to the Contractor; or~~
 - ~~(2) By deduction of amounts assessed as liquidated damages from, and as set off against payments due to the Contractor or that become due at any time after assessment of the liquidated damages. OHA will make deductions until it has collected the full amount payable by the Contractor.~~~~
- ~~f. Contractor will not pass through liquidated damages imposed under this Contract to a Provider or Subcontractor, unless the Provider or Subcontractor caused the damage through its own action or inaction. Nothing described herein shall prohibit a Provider or a Subcontractor from seeking judgment before an appropriate court in situations where it is unclear that the Provider or the Subcontractor caused the damage by an action or inaction.~~
- ~~g. All liquidated damages imposed pursuant to this Contract, whether paid or due, shall be paid by the Contractor out of administrative costs and profits.~~

~~h. Liquidated Damages Issues and Amounts~~

Issue	Amount
Failure to submit a DSN Provider Report in the file format and exact template specified by OHA	\$250 per day for each day the submission does not meet requirements
Failure to adjust an encounter claim to reflect a financial recoupment from a Provider	\$50 per claim
Failure to timely submit a reporting deliverable by the due date specified in Contract	\$250 per day for each day the deliverable is late
Failure to report the “for cause” termination of a Provider from the Contractor’s network within timeframes specified in Contract	\$250 per occurrence
Failure to implement the provisions of an OHA approved Corrective Action Plan by the start date specified	\$250 per day for each day beyond the start date approved by OHA
Failure to timely submit quarterly and annual audited and unaudited financial statements	\$250 per occurrence
Failure to respond to an OHA request for ad hoc reports or documentation requested within the specified timeframe	\$250 per day for each day beyond the due date specified
Failure to notify OHA of a member’s Third Party Liability coverage within timeframes specified by Contract	An amount equal to the PMPM payment Contractor received for the applicable member for each month the Contractor failed to report the TPL information to OHA

~~i. If Contractor is unable to meet a program deadline or a submission deadline, Contractor shall submit a written request to the OHA Contract Administrator for an extension of the deadline, as soon as possible, but no later than 2PM on the date of the deadline in question. Requests for extensions should only be submitted when unforeseeable circumstances have made it impossible for the Contractor to meet a deadline specified in this Contract. OHA will evaluate the request based on this standard and may assess liquidated damages for late submission unless OHA has granted written approval for a deadline extension request.~~

~~6. Intermediate Sanctions~~

~~7. a. Civil ~~Monetary~~Money Penalties: OAR 410-141-3259~~

~~a. (1) Contractor acknowledges that any failure to meet ~~the responsibilities~~its obligations or specific performance standards for access and service delivery outlined in the Contract is a breach of this Contract which negatively impacts Members and the overall goals of Health System Transformation.~~

~~(2) — The civil monetary penalties outlined in this section are intended to penalize an act or the failure to act in a manner which could result in harm to a member or otherwise inhibit (as such goals are set forth in Ex. B, Part 10 of this Contract) by inhibiting timely and appropriate access to care, and thus puts Members at risk of harm. Pursuant to the authority granted to OHA under 42 CFR §438.702(b) and in accordance with OAR 410-141-3259, OHA has the right to impose civil money penalties as follows:~~

~~(3) — Financial Penalty Issues and Amounts~~

<u>(1)</u>	Failure to terminate a provider <u>Provider</u> who becomes ineligible to participate in Medicaid	\$500 per occurrence in addition to \$250 per day until the provider <u>Provider</u> is terminated
<u>(2)</u>	<u>Failure to report the “for cause” termination of a Provider from the Contractor’s network within timeframes specified in Contract</u>	<u>\$250 per occurrence</u>
<u>(3)</u>	Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination to a member <u>Member</u> within the timeframe defined in Contract and OAR	\$1,000 per occurrence
<u>(4)</u>	Delegation of an Appeal to a subcontractor <u>Subcontractor</u> or delegated entity in violation of Contract terms	\$1,000 per occurrence
<u>(5)</u>	Failure to provide a timely response to a Provider’s request for Prior Authorization within the timeframes defined in OAR 410-141-3225	\$250 per occurrence
<u>(6)</u>	<u>Failure to submit a DSN Provider Report in the file format and exact template specified by OHA</u>	<u>\$250 per day for each day the submission does not meet requirements</u>
<u>(7)</u>	<u>Failure to adjust an Encounter Data entry to reflect a financial Recoupment from a Provider</u>	<u>\$50 per claim</u>
<u>(8)</u>	<u>Failure to timely submit a reporting deliverable by the due date specified in Contract</u>	<u>\$250 per day for each day the deliverable is late</u>
<u>(9)</u>	<u>Failure to implement the provisions of an OHA-approved Corrective Action Plan by the start date specified</u>	<u>\$250 per day for each day beyond the start date approved by OHA</u>
<u>(10)</u>	<u>Failure to timely submit quarterly and annual audited and unaudited financial statements</u>	<u>\$250 per day for each day the deliverable is late</u>
<u>(11)</u>	<u>Failure to respond to an OHA request for ad hoc reports or documentation requested within the specified timeframe</u>	<u>\$250 per day for each day beyond the due date specified</u>
<u>(12)</u>	<u>Failure to notify OHA of a Member’s Third-Party Liability coverage within timeframes specified by</u>	<u>An amount equal to the PMPM Payment Contractor received for the</u>

<u>Contract</u>	<u>applicable Member for each month the Contractor failed to report the TPL information to OHA</u>
Failure to enroll a Member on the basis of their health status or their need for health care services.	\$15,000 per member not to exceed \$100,000 per determination

- ~~b.~~ (4) Nothing in this sectionIn accordance with OAR 410-141-3259(3)(i), nothing in this Sec. 7, Ex. B, Part 9 or in Sec. 4 above of this Ex. B. Part 9 prohibits OHA from ~~issuing financial~~imposing civil money penalties ~~outside of the specific infractions identified in (3)~~ for any ~~instance of Contractor's other act or~~ failure to ~~perform or meet requirements~~act by Contractor that constitutes a breach of this Contract.
- ~~c.~~ (5) If OHA elects to issueimpose a financial civil money penalty for ~~an infraction that is a breach~~ not listed this Sec. 7, Ex. B, Part 9 or in (3) Sec. 4 above, of this Ex. B, Part 9 the specific amount of the penalty ~~is at OHA's discretion~~will be determined in accordance with OAR 410-141-3259.

8. ~~7.~~ Sanction Process

- ~~a.~~ OHA will notifyIn the event OHA determines Contractor ~~in writing~~will be subject to one or more Sanctions. OHA will provide Contractor with Legal Notice of its intent to impose a ~~sanction~~Sanction(s). The ~~notification shall~~Legal Notice will explain the factual basis for the ~~sanction~~Sanction(s), reference to the ~~section~~applicable Section(s) of this Contract or applicable federal ~~or~~ State law ~~or regulation~~ that has been violated, ~~explain~~identify the actions ~~expected of~~ to be undertaken by Contractor to remedy the breach, and state the Contractor's right to file, in writing within thirty (30) days of the date of receipt of the Legal Notice of Sanctions, a request for Administrative Review with the Director of OHA ~~in writing within 30 days of the date of the sanction notice.~~
- ~~b.~~ In cases ~~in which~~where OHA determines that conditions could compromise a Member's health or safety, including compromising a Member's access to care, OHA may provisionally impose the ~~sanction~~Sanction before ~~such a requested~~ Administrative Review ~~opportunity~~ is providedcommenced or completed.
- ~~c.~~ Contractor ~~shall make payments~~must pay civil money penalties in full to OHA within thirty (30) days of the date of the sanction notice, unless Contractor has made a timely written request for Administrative Review in ~~which case~~accordance with Para. a above of this Sec. 8, Ex. B, Part 9 and OAR 410-120-1580. In such event, Contractor may withhold payment of ~~a all or any~~ disputed amount of a civil money penalty imposed pending the issuance of the Administrative Review decision. Absent a timely request for Administrative Review, if Contractor fails to make payment within thirty (30) days of the sanction noticereceiving Legal Notice of the Sanction, OHA will ~~recoup~~setoff the ~~recovery payment~~full sum of the civil money penalty from Contractor's future ~~CCO~~ Payment(s) or as otherwise provided under this Contract, until the ~~payment is satisfied~~civil money penalty is paid in full.
- ~~d.~~ Contractor will not pass through civil money penalties imposed under this Contract to a Provider or Subcontractor, unless the Provider or Subcontractor caused the damage through its own actions or inactions. In addition, civil money penalties, whether paid or due must be paid by Contractor out of its profits or other administrative funds.

~~e.~~ ~~d.~~—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 ~~sanction~~Sanction decisions under this Contract.

~~e.~~—~~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.~~

9. ~~8.~~ Notice to CMS of Contractor Sanction

In accordance with 42 CFR §438.724, OHA will provide written notice to the CMS Regional Office no later than thirty (30) days after OHA has imposed ~~a sanction~~or lifted a Sanction, including civil money penalties, on Contractor ~~in accordance with 42 CFR 438.724. OHA may choose to provide written notice to the CMS Regional Office whenever Contractor has a civil monetary penalty imposed by OHA for any breach or violation of this Contract.~~

~~9.~~ 9. Compliance Plan

~~a.~~—~~Contractor shall develop and implement a Compliance Plan in accordance with requirements in 42 CFR §438.608 to detect and prevent potential Fraud, Waste and Abuse activities. This plan at a minimum, must include:~~

~~(1) Procedures and a system with dedicated staff for:~~

~~(a) Routine internal monitoring and auditing of compliance risks;~~

~~(b) Prompt response to compliance issues as they are raised;~~

~~(c) Investigation of potential compliance problems as identified in the course of self-evaluation and audits;~~

~~(d) Correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence;~~

~~(e) Ongoing compliance with the requirements under the contract;~~

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

~~(g) The development and implementation of an annual plan to audit network providers and validate the accuracy of encounter claims data against provider charts;~~

~~(h) Procedures to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;~~

~~(i) A system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality;~~

~~(j) A mechanism for a network provider to report an overpayment to Contractor and to return the overpayment within 60 calendar days after the date on which the~~

~~overpayment was identified, and to notify the Contractor in writing, the reason for the overpayment;~~

- ~~(k) — Provision for reporting to OHA within 60 calendar days when Contractor has identified the capitation payments or other payments in excess of amounts specified in the Contract;~~
- ~~(l) — Provision for prompt reporting to OHA of all overpayments identified or recovered, specifying overpayments due to fraud, waste and abuse on the quarterly and annual exhibit L financial report;~~
- ~~(m) — Member Grievance and Appeal resolution processes protecting the anonymity of complaints and to protect callers from retaliation; and~~
- ~~(n) — Procedures for prompt notification to OHA when Contractor receives information about changes in an enrollee's circumstances that might impact eligibility, including:—~~
 - ~~(a) — Changes in an enrollee's residence; and~~
 - ~~(b) — The death of an enrollee~~

- ~~b. — Contractor shall report to the Federal Department of Health and Human Services (DHHS), Office of the Inspector General (OIG), 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 System for Award Management (SAM). Reporting requirement can be met by submitting information to OHA Provider Services.~~
- ~~e. — Contractor shall provide notification to OHA within 30 days when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement;~~
- ~~d. — Contractor shall provide a quarterly report of all audits performed using the Quarterly FWA Report Template including information on any overpayment that was recovered, the source of the overpayment recovery, and any sanctions or Corrective Actions imposed by Contractor on its subcontractors or Providers. The Quarterly FWA Report is due 30 days following the end of each quarter.~~
- ~~e. — Contractor shall provide an annual summary report of referrals, cases investigated, and audits on the Annual FWA Report Template. The Annual FWA Report Template is due January 31st for activity performed during the prior contract year.~~

10. Assessment of Compliance Activities~~Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures.~~

- ~~a. Contractor shall provide an annual assessment of the quality of the Fraud, Waste and Abuse program, including the number of preliminary investigations and the number of referrals to OHA PAU or MFCU, training and education for employees, CCO Compliance Officer, other CCOs, and Subcontractors. As set forth in additional detail in Sections 11-18 below of this Ex. B, Part 9, Contractor is responsible for: (i) developing and implementing Fraud, Waste, and Abuse prevention policies and procedures that ensures compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, and OAR 410-120-1510; and (ii) annually creating a plan for implementing its policies and procedures.~~

- ~~b. The assessment report must address compliance and Fraud, Waste and Abuse activities that were performed during the reporting year, including a review the provider audit activity performed based on the audit plan, describing the methodology used to identify high-risk providers or services, compliance reviews of subcontractors and delegated entities, and any applicable request for technical assistance from OHA on improving the compliance activities performed by Contractor. Pursuant to 42 CFR § 438.608, to the extent that Contractor subcontracts to any third parties any responsibility for providing services to Members or processing and paying for claims, Contractor shall require its Subcontractors, pursuant to its Subcontracts, to comply with the terms and conditions set forth in Sections 11-18 below of this Ex. B, Part 9.~~
- ~~e. The assessment must describe the outcomes of these activities, and identify proposed or future process improvements to address deficiencies. Progress reports must be completed using the template OHA provides and makes available on its website.~~

Deliverable	Deliverable Date
Assessment of Compliance Activities	January 31, 2021

- ~~d. Contractor shall submit to OHA a sample of the Verification of Services letters distributed to members, including member response rates to the mailings, the frequency of mailings, and describe how members are selected to receive service verification surveys.~~

11. Contractor’s Fraud, Waste, and Abuse Prevention Policies and Procedures

- a. Contractor ~~shall~~must develop a Fraud, Waste, and Abuse Prevention Handbook wherein Contractor sets forth its written policies and procedures, and implement a mandatory compliance plan, in accordance with ~~OAR 410-120-1510~~the requirements set forth in 42 CFR §§438.600-438.610, 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 1002, and OAR 141-120-1510 that will enable ~~the Contractor or its Subcontractors or Participating Providers~~ to detect and prevent and detect potential Fraud, Waste, and Abuse activities ~~in the Medicaid system. These policies, at a minimum, must include:~~that have been engaged in by its employees, Subcontractors, Providers, Members, and other third parties.
- b. The Contractor FWA Prevention Handbook must include, at a minimum, all of the following:
 - ~~(1) Written standards of conduct for Contractor’s employees and Subcontractors that demonstrate compliance with all applicable requirements under the Contract, and that articulate Contractor’s commitment to comply with all applicable federal and State laws;~~
 - (1) (2) A designated Designation and identification of a Chief Compliance Officer who reports directly to the CEO and the Board of Directors and who is responsible for: (i) developing and implementing related the written policies, and procedures and practices, and who reports directly to the CEO and the Board of Directors set forth in this Para. b, Sec. 11, Ex. B, Part 9, and (ii) creating the Annual FWA Prevention Plan (as such Plan is described in Sec. 12 below of this Ex. B, Part 9);
 - (2) (3) The establishment Establishment and identification of the members of a Regulatory Compliance Committee at the Board of Directors and, which shall include Contractor’s Chief Compliance Officer, senior management level charged with management employees, and members of the Board of Directors. The Regulatory Compliance

- Committee will be responsible for overseeing the Contractor's ~~compliance~~Fraud, Waste, and Abuse prevention program and ~~its~~ compliance with the ~~requirements under~~terms and conditions of this Contract;
- (3) Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and which includes at least one employee who reports directly to the Chief Compliance Officer;
- (4) ~~A system to provide training and education for the Compliance Officer, the organization's senior management, and the organization's employees and Subcontractor for the Federal and State standards and requirements under this contract;~~ A statement or narrative that articulates Contractor's commitment to complying with the terms and conditions set forth in this Sec. 11, and Secs. 12-18 of this Ex. B, Part 9 and all other applicable State and federal laws;
- (5) ~~A system to provide education to credentialing and contracting staff including provisions prohibiting the employment of sanctioned individuals by Contractor and its Subcontractors;~~ Written standards of conduct for all of Contractor's employees that evidences compliance with Contractor's commitment to Fraud, Waste, and Abuse prevention and enforcement in accordance with the terms and conditions of this Contract and all other applicable State and federal laws;
- ~~(6) Systems designed to maintain effective lines of communication between Contractor's compliance office and Contractor's employees;~~
- (6) ~~(7)~~ A description of Contractor's disciplinary guidelines used to enforce compliance standards and how those guidelines are publicized;
- (7) A system to provide and require annual attendance at training and education regarding Contractor's Fraud, Waste, and Abuse policies and procedures. Such training and education must include, without limitation, the right, pursuant to Section 1902(a)(68) of the Social Security Act, to be protected as a whistleblower for reporting any Fraud, Waste, or Abuse. All such training and education must be provided to, and attended by, Contractor's Compliance Officer, senior management, and all of Contractor's other employees;
- (8) In addition to the training and education required under Sub. Para. (5) above, of this Para. b, Sec. 11, Ex. B, Part 9, a system to provide annual education and training to Contractor's employees who are responsible for credentialing Providers and Subcontracting with third parties. Such annual education and training must include material relating to, as set forth in 42 CFR §§438.608(b) and 438.214(d): (i) the credentialing and enrollment of Providers and Subcontractors and (ii) the prohibition of employing, Subcontracting, or otherwise being Affiliated with (or any combination or all of the foregoing) with sanctioned individuals;
- (9) Systems designed to maintain effective lines of communication between Contractor's Compliance Office and Contractor's employees and Subcontractors;
- (10) ~~(8)~~ Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees or Subcontractors who have violated Fraud, Waste and Abuse policies ~~or~~ and procedures and any other applicable

~~State and federal or state statutes, regulations, federal or state health care requirements~~laws;

- ~~(9) Information in the employee handbook for the Contractor's employees and in written policies for its Subcontractors, including a specific discussion of the applicable Fraud, Waste 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; and~~
- ~~(10) A procedure for submitting these policies annually to the OHA's Contract Administrator and other appropriate bodies charged with responsibility of operating and monitoring the Fraud, Waste and Abuse program.~~
- (11) Procedures for reporting Fraud, Waste, and Abuse to the appropriate agencies in accordance with Section 17 below of this Ex. B, Part 9;
- (12) Provisions that provide detailed information about the State and federal False Claims Acts and other applicable State and federal laws, including, as provided for section 1902(a)(68) of the Social Security Act and the protections afforded to those persons who report Fraud, Waste, and Abuse under applicable whistleblower laws. The disclosures described in this Sub. Para (12) are required of Contractor only if it receives or makes payments of at least five million dollars (\$5,000,000) annually as a result of its performance under this Contract;
- (13) Procedures to routinely verify whether services that have been represented to have been delivered by network Providers were received by Members. Such verification must be made by: (i) mailing service verification letters to Members, (ii) sampling, or (iii) other methods;
- (14) A system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees, Providers, Subcontractors, and Members, while maintaining the confidentiality of the person(s) posing questions or making reports;
- (15) Provisions for Contractor to self-report to OHA any Overpayment it received from OHA under this Contract or any other contract, agreement, or MOU entered into by Contractor and OHA. The foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305 such Overpayment to OHA within sixty (60) days of its identification;
- (16) Provisions for Contractor to report to OHA any Overpayments made to Providers, Subcontractors, or other third parties, regardless of whether such Overpayment was made as a result of the self-reporting by a Provider, Subcontractor, other third-party, or identified by Contractor and regardless of whether such Overpayment was the result of an Fraud, Waste, or Abuse or accounting error. If identification of Overpayment was the result of self-reporting to Contractor by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR §401.305, such Overpayment within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment. If Overpayment was identified by Contractor as a result of an audit or investigation, such Overpayment must be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment. If Contractor suspects an Overpayment identified during an audit or investigation is due to Fraud, Waste, or Abuse, such Overpayment must be

reported in accordance with Sec. 17 below of this Ex. B, Part 9. All such reports made by the Provider, Subcontractor, or other third-party must include a written statement identifying the reason(s) for the return of the Excess Payment;

(17) In addition to the procedures for reporting required under Sub. Para. (11) above of this Para. b, Ex. B, Part 9, a procedure for accurately reporting on the quarterly and annual Financial Reports required under Sec. 1, Para. a., Sub-Para. (2), Ex. L all Overpayments, identified or recovered regardless of whether the Overpayments were the result of (i) self-reporting under Sub-Paras. (15) and (16) above of this Para. b Sec. 11, Ex. B, Part 9, or (ii) the result of a routine or planned audit or other review;

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

(19) Procedures for prompt notification to OHA when Contractor receives information about changes in a Member's circumstances that might impact eligibility, including: (i) changes in a Member's residence, and (ii) death of a Member; and

(20) A procedure pursuant to which Contractor shall provide OHA with Administrative Notice of any information it receives about a change in a Provider's circumstances that may affect the Provider's eligibility to provide services on behalf of Contractor or any other CCO, including the termination of the Provider agreement. Such Administrative Notice must be made within thirty (30) days of receipt of such information.

c. Contractor must provide its FWA Prevention Handbook to all employees or otherwise include its complete contents in Contractor's employee Handbook. Contractor must include, at a minimum, in its Member Handbook the following information relating to Fraud, Waste, and Abuse:

(1) A statement or narrative that articulates Contractor's commitment to: (i) preventing Fraud, Waste, and Abuse, and (ii) complying with all Applicable Laws, including, without limitation the State's False Claims Act and the federal False Claims Act;

(2) Examples of Fraud, Waste, and Abuse;

(3) Where and how to report Fraud, Waste, and Abuse; and

(4) A Member's right to be report Fraud, Waste, and Abuse anonymously, and to be protected under applicable Whistleblower laws.

12. ~~Review of Compliance Plan and Fraud, Waste and Abuse Policies~~ In addition to creating the written FWA Prevention Handbook, Contractor, through its Chief Compliance Officer, with the assistance of Contractor's Compliance Office, must annually draft a written plan for implementing, analyzing, and reporting on the effectiveness of the policies and procedures set forth in Contractor's FWA Prevention Handbook.

a. ~~Contractor shall review and update its Compliance Plan and Fraud, Waste and Abuse policies annually and submit a written copy to OHA Contract Administration Unit. After review, OHA will notify Contractor within 30 calendar days of the compliance status. Contractor shall modify and resubmit policies or procedures deemed out of compliance until OHA determines that they meet applicable state and federal regulations. Copies must be submitted as follows:~~ Contractor's Annual FWA Prevention Plan, must include, at a minimum, written plans and procedures for all of the following activities:

- (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.~~ Routine internal Monitoring, reporting, and auditing of Fraud, Waste, and Abuse risks and other related compliance risks;
- (2) Prompt response to Fraud, Waste, and Abuse and other related compliance issues as they are reported or otherwise discovered;
- (3) Investigation of potential Fraud, Waste, and Abuse and other related compliance problems as identified in the course of self-evaluation and audits;
- (4) Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of Fraud, Waste, and Abuse and other related compliance problems in a manner that is designed to reduce the potential for recurrence;
- (5) Activities that support on-going compliance with the Fraud, Waste, and Abuse prevention and other compliance requirements under this Contract;
- (6) Risk evaluation procedures to enable ~~compliance in identified problem areas such as claims, Prior Authorization, service verification, utilization management and quality review;~~ and
- (7) The development and implementation of an annual plan to audit Providers and Subcontractors that will enable Contractor to validate the accuracy of Encounter Data against Provider charts.

13. Review and Approval of Fraud, Waste, and Abuse Handbooks

- a. Contractor shall provide to OHA via Administrative Notice, its FWA Prevention Handbook and Annual FWA Prevention Plan and to OHA for review and approval by ~~no later than January 31~~ of each Contract Year. Contractor's Annual FWA Prevention Plan and the policies and procedures set forth in the FWA Prevention Handbook must not be implemented or distributed prior to approval by OHA. Review and approval shall be provided to Contractor, via Administrative Notice to Contractor's Contract Administrator, by OHA within thirty (30) days of receipt. In the event OHA disapproves of either or both the Annual FWA Prevention Plan and the FWA Prevention Handbook for failing to meet the terms and conditions of this Contract and any other applicable State and federal laws, Contractor shall, in order to remedy the deficiencies in the Annual FWA Prevention Plan and FWA Prevention Handbook, follow the process set forth in Sec. 5, Ex. D of this Contract. In addition, OHA does not approve Contractor's FWA Annual Prevention Plan or the FWA Prevention Handbook, or both, by May 31 of each Contract Year due to Contractor's non-compliance with the terms and conditions in this Contract. Contractor shall be in breach of this Contract and OHA shall have the right to pursue all of its rights and remedies under this Contract, including, without limitation, the imposition of Sanctions, including a Corrective Action Plan or the imposition of civil money penalties, or both.
- b. Contractor must review and update its Annual FWA Prevention Plan and FWA Prevention Handbook annually and provide, to OHA via Administrative Notice, copies of such documents for OHA's review and approval. In the event Contractor has not made any changes to its FWA Prevention Handbook since it was last approved by OHA, Contractor must include an attestation that no changes have been made since it was last approved. The attestation form required to be used under this Para. b, Sec. 13, Ex. B, Part 9 is located on the CCO Contract Forms Website and

identified with the title “Fraud, Waste, and Abuse Annual Attestation Template.” Review, approval, and remediation of any deficiencies therein will be subject to the process set forth in Para. a above, of this Sec. 13, Ex. B, Part 9. After OHA’s initial approval of Contractor’s Annual FWA Prevention Plan and FWA Prevention Handbook under Para. a. of this Sec. 13, Ex. B, Part 9 Contractor shall submit such Plan and Handbook for subsequent review and approval as follows:

- ~~(1)~~ ~~(2)~~ ~~To the OHA Contract Administration Unit~~ via Administrative Notice upon any significant ~~changes~~ revisions, regardless of whether such changes are made prior or subsequent to annual approval by OHA, or prior to formal Contractor’s final adoption of the policy. ~~such Plan or Handbook after initial approval by OHA. The revised Annual FWA Prevention Plan or FWA Prevention Handbook, or both. OHA will notify Contractor within 30 days of the compliance status of the policy. In the event the revised Annual FWA Prevention Plan or FWA Prevention Handbook fails to meet the terms and conditions of this Contract or Applicable Law, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.~~
- ~~(2)~~ ~~(3)~~ ~~To the OHA Contract Administration Unit~~ anytime upon OHA request. Contractor must provide OHA with the requested Annual FWA Prevention Plan or FWA Prevention Handbook, or both, in the manner requested by OHA. OHA will notify Contractor within thirty (30) days of the compliance status of the policy. In the event the revised Annual FWA Prevention Plan or FWA Prevention Handbook, or both, are not approved by OHA based on the failure to meet the terms and conditions of this Contract or any other Applicable Law, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.

~~13. Treatment of Overpayment Recoveries Due to Fraud, Waste and Abuse~~

14. OHA & Contractor Audits of Network Providers

- a. ~~Contractor may collect and retain overpayments Contractor recovers from a Provider as a result of its investigation or audit where such recoveries are the result of waste or abuse. If OHA conducts an audit of Contractor’s Providers or the Providers’ Encounter Data that results in a finding of Overpayment, OHA will calculate the final Overpayment amount for the audited claims using the applicable Fee-for-Service fee schedule and recover the Overpayment from Contractor. Contractor shall have the right, at its discretion, to pursue recovery of the Overpayments made by Contractor to the applicable Providers.~~
- b. ~~If an investigation resulted in a fraud referral to OHA and the Department of Justice Medicaid Fraud Control Unit, the Contractor must obtain written authorization from OHA prior to the initiation of any recovery due to fraud or potential fraud. If OHA conducts an audit of Contractor’s Providers or the Providers’ Encounter Data that results in an administrative or other non-financial finding, Contractor agrees to use the information included in OHA’s final audit report to rectify any identified billing issues with its Providers and pursue financial recoveries for improperly billed claims if applicable.~~
- c. ~~Contractor shall report all identified and recovered overpayments on the Exhibit L Financial Reporting Template. If Contractor or its Subcontractors conduct audits of Contractor’s Providers or Providers’ Encounter Data that results in a finding of Overpayment, Contractor must return to OHA any and all applicable federally matched funds but is permitted to keep any sums recovered in excess of the federally matched funds as calculated by OHA.~~

- d. Recoveries that are retained by Contractor must be reported as set forth in Sub-Para. (17), Sec. 11, above, of this Ex. B, Part 9 and Sec. 15, Para. b. below, of this Ex. B, Part 9.

15. Documenting and Processing Contractor Recovery of Overpayments Made to Third Parties

In addition to reporting all identified and recovered Overpayments made to Providers, Subcontractors, or other third parties in accordance with Sec. 11, Para. b, Sub-Para. (17) above, of this Ex. B, Part 9. Contractor must also comply with all of the procedures for managing and otherwise processing the recovery of such Overpayments as follows:

- a. ~~d.~~ Contractor ~~shall~~must adjust, void or replace, as appropriate, each ~~encounter~~Encounter claim to reflect the ~~proper~~Valid Encounter claim ~~adjudication~~once Contractor has recovered Overpayment within thirty (30) days of identifying such Overpayment.
- b. ~~e.~~ Contractor ~~shall~~must maintain records of Contractor's actions and Subcontractors' actions related to ~~overpayment~~the recovery, ~~and make those records~~ of Overpayments made to Providers, Subcontractors, or other third parties. Such records maintenance must be made in accordance with ~~and made~~ available ~~for to~~ OHA ~~review upon request~~ and other parties in accordance with Ex. D, Sec.14 of this Contract.
- c. ~~In the event Contractor investigates or audits its Providers, Subcontractor, or any other third-party and Overpayments made to such parties are identified as the result of Fraud, Waste, or Abuse, Contractor may collect and retain such Overpayments as set forth in Sec. 14 above of this Ex. B, Part 9.~~
- d. ~~f.~~ Examples of ~~overpayment~~Overpayment types ~~that might be made to Providers, Subcontractors, or other third parties~~ include, but are not limited to, the following:
- (1) Payments for ~~non~~Non-covered services; Covered Services.
 - (2) Payments in excess of the allowable amount for an identified covered service;.
 - (3) Errors and non-reimbursable expenditures in cost reports;.
 - (4) Duplicate payments; and
 - (5) Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retroactive recovery process;
 - ~~(6) Recoveries due to waste or abuse as found in audits, investigations or reviews; or~~
 - ~~(7) Credit balance recoveries.~~
- e. ~~This provision~~Contractor does not ~~apply~~have the right, under this Sec. 17 of this Ex. B, Part 9, to ~~retain~~ any ~~amount of a recovery to be retained~~Overpayments made to any Provider or any Subcontractor that are recovered as a result of (i) claims brought under ~~the State or federal~~ False Claims ~~Act cases~~Acts (ii) a judgment or settlement arising out of or related to litigation ~~involving claims of~~ fraud ~~cases~~, or (iii) through government investigations, such as amounts recovered by ~~the OHA and the Medicaid Fraud Control Unit~~PIAU or MFCU or any other State or federal governmental entity, regardless of whether Contractor referred the matter to such parties.

14. ~~Audits of Network Providers~~

- ~~a. If OHA conducts an audit of Contractor's Provider or encounter claims data that results in a financial finding, OHA shall calculate the final overpayment amount for the audited claims using~~

~~the applicable fee for service fee schedule and recover the overpayment from Contractor. Contractor may pursue recovery from the Provider at its discretion.~~

- ~~b. If OHA conducts an audit of Contractor's Provider or encounter claims data that results in an administrative or other non-financial finding, Contractor agrees to use the information included in the final audit report to rectify any identified billing issues with its Provider and pursue financial recoveries for improperly billed claims if applicable.~~
- ~~c. If Contractor or its Subcontractor conducts an audit of Contractor's Provider or encounter claims data that results in a financial finding, Contractor is permitted to keep the recovered amount outside of any applicable federally matched funds which must be returned to OHA.~~
- ~~d. Recoveries that are retained by Contractor must be reported on the quarterly and annual Exhibit L financial report, and the quarterly and annual FWA Reports.~~

~~15. Referral Policy~~

16. Examples of Fraud, Waste, and Abuse:

- ~~a. Contractor shall promptly refer all suspected cases~~Examples of Fraud, Waste, and Abuse, including suspected fraud committed by its employees and Subcontractors to the Medicaid Fraud Control Unit (MFCU) and the OHA Program Integrity Audit Unit (PIAU) in accordance with 42 CFR 455.23. include, without limitation, any one, combination of, or all of the following:
- ~~b. Contractor shall refer such suspected cases of fraud within 7 business days.~~
- ~~c. Contractor shall ensure its Member handbook reflects information on how to report fraud, waste and abuse.~~
 - (1) ~~Examples of Fraud, Waste and Abuse within Contractor's network may include:~~Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.
 - ~~(a) 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;~~
 - (b) Providers who consistently demonstrate a pattern of other CCOs, or Subcontractors that intentionally reporting or recklessly report 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;
 - (c) Any suspected case where the Provider Providers, other CCOs, or Subcontractors intentionally or recklessly billed Contractor or OHA more than the usual charge Usual Charge to non-Medicaid recipients Recipients or other insurance programs;
 - (d) Any suspected case where the Provider purposefully Providers, other CCOs, or Subcontractors altered, falsified, or destroyed Clinical Record documentation Records for any purpose, including, without limitation, for the purpose of artificially inflating or obscuring his or hersuch Provider's own compliance rating or collecting Medicaid payments otherwise not due. This includes any deliberateintentional misrepresentation or

omission of fact(s) that ~~is~~are 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;

- (5) ~~(e) Providers who, other CCOs, or Subcontractors that~~ intentionally or recklessly make false statements about the credentials of persons rendering care to Members;
- (6) ~~(f) Primary Care Physicians who~~Providers, other CCOs, or Subcontractors that intentionally or recklessly misrepresent medical information to justify ~~referrals~~Referrals to other networks or out-of-network Providers when ~~they~~such parties are obligated to provide the care themselves;
- (7) ~~(g) Providers who, other CCOs, Subcontractors that~~ intentionally fail to render Medically Appropriate Covered Services that they are obligated to provide to Members under ~~their Subcontracts~~this Contract, any Subcontract with the Contractor ~~and under OHP regulations; or Applicable Law.~~
- (8) ~~(h) Providers who, other CCOs, or Subcontractors that~~ knowingly charge Members for services that are Covered Services or intentionally or recklessly balance-bill a Member the difference between the total ~~fee~~Fee-for-serviceService charge and Contractor's payment to the Provider, in violation of ~~OHA rules;~~applicable law.
- (9) ~~(i) Any suspected case where the Provider~~Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment ~~that~~when such party knew the claim: (i) had already ~~has~~ been paid by OHA or Contractor, ~~or upon which payment has~~(ii) had already been ~~made~~paid 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.~~
- (10) ~~(j) Any case of theft, embezzlement or misappropriation of Title XIX or Title XXI program money.~~
- ~~(2) Examples of Fraud, Waste and Abuse in the administration of the OHP program may include:~~
- (11) Any practice that is inconsistent with sound fiscal, business, or medical practices, and which: (i) results in unnecessary costs, (ii) results in reimbursement for services that are not medically necessary, or (iii) fails to meet professionally recognized standards for health care.
- (12) ~~(a) Evidence of corruption in the Enrollment and Disenrollment process, including efforts of Contractor employees, State employees, other CCOs, or Contractors~~Subcontractors to skew the risk of unhealthy ~~patients~~Member or potential Members toward or away from ~~one of the Contractors; and~~Contractor or any other CCO.
- (13) ~~(b) Attempts by any individual, including Contractor's employees and, Providers, Subcontractors, other CCOs, Contractor, or State employees or~~ elected officials ~~of the State, to solicit kickbacks or bribes, such as. For illustrative purposes, the offer of 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~~such persons are required to provide under the terms of ~~his~~such persons' employment.

~~(3) If Contractor is made aware of a credible allegation of Fraud by MFCU, or of a pending investigation against a Provider, Contractor shall, upon notification of an investigation by MFCU, suspend payments to the Provider unless MFCU determines there is good cause not to suspend payments or to suspend payments in part, this Contract, or Applicable Law.~~

~~(4) If the act does not meet the good cause criteria, the Contractor shall work with the MFCU and OHA to determine if any Participating Provider contract should be terminated.~~

17. 16. Reporting Obligations to Report Fraud, Waste and Abuse: Policies and Procedures

a. ~~Contractor shall report to the MFCU an incident with any of the referral characteristics listed in Section 15, above. Contractor shall report to the MFCU and OHA PIAU any other incident found to have characteristics which indicate Fraud or Abuse which Contractor has verified as credible. In addition to its reporting requirements with respect to Providers under Sub. Para. (20, Sec. 11, Para. b, above, of this Ex. B, Part 9, Contractor must immediately report to the Federal Department of Health and Human Services, Office of the Inspector General, any Providers identified during the credentialing process, who are include on the List of Excluded Individuals or on the Excluded Parties List System also known as System for Award Management. Reporting requirements can be met by providing such information to OHA's Provider Services via Administrative Notice.~~

b. ~~Contractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 124.060 et seq., ORS 419B.010 et seq., ORS 430.735 et seq., ORS 441.630 et seq., and all applicable Administrative Rules. Contractor shall ensure that all Subcontractors comply with this provision. Using the FWA Report Template (found on the CCO Contract Forms Website), and in accordance with Contractor's FWA Prevention Handbook and Annual FWA Prevention Plan, Contractor must provide OHA with quarterly and annual reports of all audits performed. The Annual FWA Audit Report must include information on any Provider Overpayments that were recovered, the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by Contractor on its Subcontractors or Providers. The Annual FWA Audit Report is due January 30 of each Contract Year and quarterly FWA Report is due thirty (30) days following the end of each quarter and must be provided to OHA via Administrative Notice.~~

c. ~~Using the FWA Report Template, Contractor must provide to OHA, via Administrative Notice, an annual summary report of referrals, and cases investigated. The annual FWA Referrals & Investigations Report must be provided to OHA promptly after January 1 of each Contract Year following the reporting year but in no event later than January 31st.~~

d. ~~e. Contractor must report annually to OHA PIAU via the Annual FWA Report:~~

~~(1) Number of complaints all suspected cases of Fraud, Waste, and Abuse made, including suspected fraud committed by its employees, Providers, Subcontractors, Members, or any other third parties to the OHA PIAU or the's Program Integrity Audit Unit and DOJ's Medicaid Fraud Control Unit that warrant preliminary investigation; and, Reporting shall be made promptly but in no event more than seven (7) days after Contractor is initially made aware of the suspicious case. All reporting must be made as set forth below in Paras. h. and i below, of this Sec.17, Ex. B, Part 9.~~

~~(2) For each matter that warrants investigation, the following:~~

- ~~(a) — Name, and Member ID number~~
- ~~(b) — Source of complaint~~
- ~~(c) — Type of Provider~~
- ~~(d) — Nature of complaint~~
- ~~(e) — Approximate dollars involved~~
- ~~(f) — Legal and administrative disposition of the case~~

~~d. — Contractor must report quarterly to OHA PIAU via the Quarterly FWA Report:~~

e. Contractor must report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Sec. 16 above, of this Ex. B, Part 9. All reporting must be made as set forth below in Paras. h. and i. below, of this Sec.17, Ex. B, Part 9.

f. Contractor must cooperate in good faith with MFCU and PIAU, or their designees, in any investigation or audit relating to Fraud, Waste, or Abuse as follows:

- (1) ~~A summary of recovered overpayments;~~ Contractor must provide copies of reports or other documentation requested by MFCU, PIAU, or their respective designees, or any or all of them. All reports and documents required to be provided under this Sub-Para. (1) of this Para. f, Sec. 17, Ex. B, Part 9 must be provided without cost to MFCU, PIAU, or their designees;
- (2) ~~Any sanctions or fines administered by the Contractor~~ must permit MFCU, PIAU, or their respective designees, or any combination or all of them, to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities maintained by or on behalf of Contractor as such parties may determine is necessary to investigate any incident of Fraud, Waste, or Abuse;
- (3) ~~Details of FWA investigations and audits; and~~ Contractor must cooperate in good faith with the MFCU, PIAU, as well as their respective designees, or any or all of them, during any investigation of Fraud, Waste, or Abuse; and
- (4) ~~Any other information requested in the reporting template.~~ In the event that Contractor reports suspected Fraud, Waste, or Abuse by Contractor's Subcontractors, Providers, Members, or other third parties, or learns of an MFCU, or PIAU investigation, or any other Fraud, Waste, and Abuse investigation undertaken by any other governmental entity, Contractor is strictly prohibited from notifying, or otherwise communicating with, such parties about such report(s) or investigation(s).

g. Subject to 42 C.F.R. §455.23, in the event OHA determines that a credible allegation of fraud has been made against Contractor, OHA will have the right to suspend, in whole or in part, Payments made to Contractor. In the event OHA determines that a credible allegation of fraud has been made against Contractor's Subcontractors, OHA will also have the right to direct Contractor to suspend, in whole or in part, the payment of fees to any and all such Subcontractors. Subject to 42 C.F.R. §455.23(c) suspension of Payments or other sums may be temporary. OHA has the right to forgo suspension and continue making Payments, or refrain from directing Contractor to suspend payment of sums to its Subcontractors, if certain good cause exceptions are met as provided for under 42 C.F.R. §455.23(e). In the event OHA determines a credible allegation of fraud has been made against a Subcontractor, Contract must cooperate with OHA to determine, in accordance with the criteria set forth in 42 C.F.R. §455.23, whether sums otherwise payable by

Contractor to such Subcontractor, must be suspended or whether good cause exists not to suspend such payments.

h. ~~e.~~ Where to ~~Refer~~Report a Case of Fraud or Abuse by a Provider

(1) Contractor, if made aware of any suspected Fraud, Waste, or Abuse by a Provider, Subcontractor, or its own employees, must report the incident to MFCU and PIAU as required under this Ex, B, Part 9. Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

Medicaid Fraud Control Unit (MFCU)

Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

OHA Program Integrity Audit Unit (PIAU)

3406 Cherry Ave. NE
Salem, OR 97303-4924
~~Phone: 503-378-8113~~
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)

~~f.~~ ~~Obligations to Assist the MFCU and OHA~~

- ~~(1)~~** ~~Contractor shall permit the MFCU or OHA PIAU 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, Waste and Abuse.~~
- ~~(2)~~** ~~Contractor shall cooperate, and requires its Subcontractors to cooperate, with the MFCU and OHA PIAU investigator during any investigation of Fraud or Abuse. Contractor must include the above contact information for MFCU and PIAU in its FWA Prevention Handbook and its Member Handbook.~~
- ~~(3)~~** ~~In the event that Contractor reports suspected subcontractor Fraud or Abuse, or learns of an MFCU or OHA PIAU 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 PIAU during an investigation.~~

i. ~~g.~~ How ~~Where~~ to ~~Refer~~Report a Case of Fraud or Abuse by a Member

(1) Contractor, if made aware of suspected Fraud or Abuse by a Member (e.g. a Provider reporting Member Fraud, Waste and Abuse) ~~shall~~must promptly report the incident to the DHS/OHA Fraud Investigation Unit. ~~Contractor shall address suspected Member Fraud,~~

~~Waste and Abuse reports to~~ Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS/OHA Fraud Investigation
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline

~~h.~~ **~~Abuse Reporting and Protective Services~~**

~~(2)~~ Contractor must include the above contact information for DHS/OHA Fraud Investigation in its FWA Prevention Handbook and its Member Handbook.

18. Assessment of Compliance Activities

a. Contractor must Submit an annual assessment report of the quality and effectiveness of its Annual FWA Prevention Plan and the related policies and procedures included in its FWA Prevention Handbook . The Annual FWA Assessment Report must include an introductory narrative of the foregoing efforts and effectiveness.

b. The Annual FWA Assessment Report must include, with respect to the previous Contract Year, all of the following information:

~~(1) Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in OAR 407-045-0000 through 407-045-0370 and ORS 430.735 through 430.765. This includes all patients observed in an office setting. Examples of abuse and neglect:~~ Identify the number of preliminary investigations and the final number of referrals to PIAU or MFCU or both;

~~(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).~~

~~(2)~~ Identify the number of Subcontractor and Provider audits and the number of Subcontractor and Provider reviews were conducted by Contractor and whether they were performed on-site or based on a review of documentation;

~~(3)~~ Identify the training and education provided to and attended by Contractor's Chief Compliance Officer, its employees, and, if applicable, its Providers and Subcontractors;

- (4) Compliance and Fraud, Waste, and Abuse prevention activities that were performed during the reporting year. Such report must include: (i) a review of the Provider audit activity Contractor performed and whether such audit activity was in accordance with Contractor's Annual FWA Prevention Plan, (ii) a description of the methodology used to identify high-risk Providers and services, (iii) compliance reviews of Subcontractors, Providers, and any other third parties, including a description of the data analytics relied upon, and (iv) any applicable request for technical assistance from OHA on improving the compliance activities performed by Contractor; Include a sample of the Service Verification Letters mailed to Members, and report on: (i) the number of Service Verification letters sent, (ii) how Members were selected to receive such Letters, (iii) Member response rates, (iv) the frequency of mailings, including all dates on which such Letters were mailed, (v) the results of the efforts, and (vi) other methodologies used to ensure the accuracy of data; and
- (5) A narrative and other information that advises OHA of: (i) the outcomes of all of the Fraud, Waste, and Abuse prevention activities undertaken by Contractor, and (ii) proposed or future process, policies, and procedure improvements to address deficiencies identified.
- c. Contractor's Annual FWA Assessment Report must be provided to OHA via Administrative Notice by no later than January 31 of each Contract Years two, three, and four. OHA will advise Contractor of its reporting requirements for Contract Year five at least one-hundred and twenty (120) days prior to the Contract Termination Date.

[Remainder of page intentionally left blank]

~~(a)~~

**Exhibit B—Statement of Work - Part 10—~~Quality,~~
Transformation Reporting, Performance ~~Outcomes~~Measures and ~~Accountability~~External Quality
Review**

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~~strategies undertaken by Contractor are effective in achieving, or progressing towards meeting, the Triple Aim goals of improving both the care provided to Members and Member health, all at a lower cost. To this end, initial and ongoing data collection, analysis, and follow-up action are required of Contractor. ~~Contractor's obligations under the Transformation and Quality Amendment are obligations under this Contract. The purpose of this Exhibit B—Statement of Work Part 9 is to set forth the procedure~~The foregoing work requires Contractor shall follow to maintain theproduce and provide to OHA three separate deliverables as follows: (i) a Transformation and Quality Strategy, ~~ongoing performance measurement, and requirements for compliance with state and federal regulations for quality monitoring~~(ii) Performance Measures, and (iii) Performance Improvement Projects, all of which must comply with the criteria set forth in 42 CFR §§438.66 and 438.330, the State's 1115 Waiver, this Ex. B, Part 10 and other Applicable Law.

2. Transformation and Quality Strategy Requirements

- a. ~~In moving Health System Transformation toward achieving the Triple Aim goals, Contractor shall maintain~~create a Transformation and Quality Strategy ~~(. The TQS) throughout is the term of this contract. Contractor's strategy must include, at minimum, the components of~~means by which Contractor shall identify strategies and activities related to Health System Transformation and quality assurance performance. The TQS will also set forth Contractor's methods and means for Monitoring progress and improvement and subsequent reporting related to Health Transformation and quality assurance as required under, and in accordance with, the State's 1115 Waiver, OAR 410-141-3200(8), and 42 CFR §438.330(a) and (b) relating to Quality Assurance and Performance Improvement Program (QAPI), in accordance with 42 CFR 438.330 and health transformation.
- ~~b. The Transformation and Quality strategy identifies the goals, objectives and intended outcomes for the annual QAPI program, including the health innovation transformation activities. The TQS template includes project and the goal with enough detail to demonstrate and monitor performance improvement.~~
- ~~c. Transformation and Quality Strategy submission section requirements:~~
- b. Contractor's TQS must be drafted using, and comply with the requirements set forth in, the TQS guidance document and TQS template. The TQS guidance document ~~details the TQS content and attachments required~~and template for Contract Year one will be made available to Contractor by the Contract Effective Date and for submission. TQS guidance documentContract Years two through five, such documents and templates will be updated annually by OHA and posted made available to Contractor no later than October 1. All TQS information and resources are posted on the OHA Transformation Center TQS website.
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx>

- ~~d. Transformation and Quality Strategy template and progress report templates provided by OHA will be required for submission by contractor. Details of the aforementioned will be available on the OHA Transformation website—
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx> each Contract Year.~~
- ~~e. Contractor shall have in effect a process for its own evaluation of the impact and effectiveness of its systems interventions of its quality program.~~
- ~~f. Contractor will include the basic elements of a QAPI Subsections (1) through (8) of paragraph g- 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 oral health care.~~
- ~~g. Contractor shall include in the annual QAPI program evaluation:~~
- ~~(1) Contractor shall submit its annual TQS, via Administrative Notice, to OHA for review and approval on March 15 of each Contract Year. OHA shall review Contractor's annual TQS for compliance with the terms and conditions of this Sec. 2 of Ex. B, Part 10 and other applicable provisions of this Contract. In the event OHA does not approve Contractor's TQS, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract.~~
 - ~~(2) The TQS guidance document and template for all Contract Years, and additional information and resources related to the TQS, are posted on the OHA Transformation technical assistance webpage located at:
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx>~~
- ~~c. As set forth in the TQS guidance document, Contractor's TQS must include strategies and activities as required under the State's 1115 Waiver, 42 CFR §438.330 (a) and (b), and other federal obligations to improve certain elements of the services provided by Contractor to Members as set forth below in this Para. c, Sec. 2 of Ex. B, Part 10, as well as information about processes and procedures related to the TQS. Accordingly, the TQS must include, without limitation the following:~~
- ~~(1) As per OAR 410-141-0200, contractor shall have a quality committee to oversee QAPI and transformation program. Such committee serves as structure for quality and transformation. An internal quality improvement committee that monitors the annual quality strategy and work plan; In accordance with the State's 1115 Waiver, strategies and related activities to improve Quality and appropriateness of care and Health Equity with respect to REAL+D, Cultural Competency, and CLAS standards and criteria~~
 - ~~(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: (i) detect both under utilization and over utilization of services; (ii) to document the findings; (ii) to report aggregate data indicating the number of enrollees identified (iv) and to describe follow-up actions for both findings; In accordance with federal requirements including those under 42 CFR §438.330 (a) and (b) related to Quality Assessment and Improvement Program obligations;~~

- ~~(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;~~
- ~~(a) (5) A demonstration of improvement in an area of poor performance in care coordination~~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;~~
- ~~(b) (6) A report on the grievance system~~Contractor's Grievance and Appeal System, inclusive of complaints, ~~notice~~Notices of actions, ~~appeals and hearings~~Adverse Benefit Determination, Appeals, and Contested Case Hearings,
- ~~(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) Participation as a member of the OHA Quality and Health Outcomes Committee (QHOC).~~

~~3. Revised Transformation and Quality Strategy~~

~~At OHA's request, or as required by an amendment to the Contract, Contractor shall make changes to its Transformation and Quality Strategy by furnishing OHA with a revised draft of the Strategy and areas of transformation with the requested changes on date(s) set by OHA. Contractor and OHA will exchange drafts of the Transformation and Quality Strategy so that OHA approves them on the date(s) set by OHA. Changes to the Areas of Transformation within the TQS are amendments to this Contract and may be subject to approval by DOJ and CMS.~~

~~4. Transformation and Quality Strategy Monitoring and Compliance Review~~

- ~~(c) Quality and appropriateness of care furnished to Members with Special Health Care Needs; and~~
- ~~(d) Mechanisms to Monitor both over- and under-utilization of services.~~
- ~~(3) Identification of the processes and procedures Contractor will use, and data that will be collected and relied upon, to evaluate the impact and effectiveness of the strategies and activities undertaken to move toward Health System Transformation and improve quality assurance; and~~
- ~~(4) A narrative of the involvement of Contractor's Community Advisory Council in the development of the TQS.~~
- ~~d. In addition to the TQS, Contractor shall draft and provide to OHA an annual TQS Progress Report using the TQS guidance document and the TQS Progress Report Template. The TQS Progress Report Template shall be: (i) made available to or provided directly to Contractor for Contract Year one by the Contract Effective Date, (ii) made available to Contractor for Contract~~

Years two through five by October 1 of each Contract Year on the OHA Transformation technical assistance webpage identified in Para. b above of this Sec. 2 of Ex. B, Part 10 or (ii) provided directly to Contractor by October 1 of each Contract Year.

(1) The annual TQS Progress Report shall include, without limitation:

- (a) Describe action taken or being undertaken that illustrates the TQS activities ~~and process improvements;~~
- (b) Report and analyze data that illustrates the effectiveness and progress toward achieving Triple Aim goals;
- (c) Identify areas where Contractor ~~encountered barriers to achieving goals and efforts undertaken to overcome barriers; and~~
- (d) Describe follow-up strategies and actions required to be undertaken to in support of continued progress and enable the removal of existing, remaining, and anticipated barriers.

(2) Contractor shall submit its annual TQS Progress report, via Administrative Notice, to OHA for review and approval on September 30 of each Contract Year. OHA shall review Contractor ~~agrees to's~~ TQS Progress report to determine whether Contractor is making progress toward achieving the objectives and timelines identified in its Transformation and Quality Strategy and areas of transformation and to demonstrating progress consistent with the Strategy and Areas of Transformation. OHA will monitor Contractor's compliance with the requirements in its Strategy and areas of transformation and with other elements of Quality, Health System Transformation in the Statement of Work. ~~TQS.~~

- (a) Contractor shall ~~make~~ provide its records and facilities available for OHA's compliance review, consistent with Exhibit D, Section 13 of this Contract all documentation supporting the data and information included in its annual TQS Progress Report to OHA upon request by OHA.

~~The requirements of this Exhibit B—Part 9 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.—~~

~~OHA will monitor Contractor's progress in achieving its Transformation and Quality Strategy and areas of transformation.—~~

- (b) Contractor shall allow OHA to have access to its facilities to review any documents, information, computer systems, including hardware used for creating and collecting data and documents related to the TQS as may requested by OHA.
- (c) If OHA cannot confirm, from its review of Contractor's annual TQS Progress Report, Contractor's progress toward the Triple Aim goals of Health System Transformation and Quality Assurance Performance Improvement in compliance with its ~~Strategy~~ CERs and ~~Areas of Transformation~~ the State's 1115 Waiver, OHA will ~~notify~~ provide Contractor's Contract Administrator with Administrative Notice of such failure and give the Contractor the opportunity to demonstrate evidence of progress and compliance ~~with its Strategy and Areas of~~

~~Transformation before seeking to impose Sanctions under this Contract, and to pursue~~before pursuing any of its other rights and remedies ~~available~~ under this Contract.

~~5. Transformation and Quality Strategy Deliverables~~

~~Contractor shall provide the following deliverables on the schedule described below (or any amended schedule set by amendment to its Strategy and Areas of Transformation). Contractor shall use the provided templates for submission. Templates and guidance document will be posted to CCO Contracts forms website as described under this exhibit, Section 2, part c.~~

Deliverable	Deliverable Date
(1) 2020 Transformation and Quality Strategy	March 15, 2020
(2) 2020 Transformation and Quality Progress report	September 30, 2020

~~The Transformation and Quality Progress report must address each transformational area, including actions taken or being taken to illustrate outcomes of these activities, and process improvements. Contractor shall also describe how its Community Advisory Council (CAC) was involved in the process of developing the Transformation and Quality Strategy and informed of the progress in each transformation area to meet objectives and goals.~~

~~The progress report must also identify any areas where the Contractor has encountered barriers to achieving goals and describe its strategies and efforts to overcome barriers.~~

~~Progress reports must be completed using the template OHA provides and makes available on its website. <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx>~~

~~6. Goals for Transformation and Quality Strategy Amendments~~

~~Within each of the Transformation Areas, contractor will establish one or more goals. Progress will be measured from the Baseline.~~

~~e. Notwithstanding Contractor's compliance with this Sec. 2, Ex. B, Part 10, Contractor may, when and where applicable, integrate the federal quality assessment requirements under 42 CFR §438.330 (a) and (b) and any other Applicable Laws into or with Contractor's own QAPI program for Monitoring and ensure the quality of the services provided to Members.~~

~~3. 7. Quality and Performance Outcomes Measures~~

~~a. As required by Health System Transformation, Contractor shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into standards set forth in this Contract.~~

~~In accordance with schedules established for performance measures, Contractor must:~~

~~a. Measure Accordingly, Contractor shall, as required under 42 CFR §438.330 (a) and (c), measure and report to OHA its performance, using standard measures required by OHA; and as set forth in this Sec. 3, Ex. B, Part 10.~~

- ~~(1) b. Submit data specified by OHA, that enables OHA to measure the Contractor's performance; 8., as documented in its 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 Data, shall serve as the basis for determining Contractor's eligibility for financial and non-financial rewards, incentives, including, without limitation, payments made out of the Quality Pool as set forth in further detail in Sec. 4 below of this Ex. B, Part 10.~~
- b. Contractor shall provide OHA with Performance Data throughout the Term of the Contract. Without limiting any other provision of this Contract, by virtue of submitting its Performance Data under this Sec. 3 and Sec. 4 below of this Ex. B, Part 10, Contractor is attesting to the truthfulness and accuracy of such Performance Data.
- (1) The Performance Data to be submitted, the format in which such Data must be submitted (e.g., .doc, .docx, .xlsx, or other), and the means by which such Data shall be submitted (via secure email, web portal, SFTP, or other) are set forth in the Performance Measures guidance documents made available to Contractor at the following URL: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>
- c. In general, Contractor's Performance Data will include data related to the quality of health care and services during a time period in which Contractor provided specific Covered Services.
- (1) The Performance Data submitted by Contractor for a given Contract Year will be analyzed by OHA against certain metrics, benchmarks, and improvement targets as determined by the Metrics and Scoring Committee. The items to be measured, metrics, benchmarks and improvement targets for each Contract Year are located at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>
- (2) d. OHA's The Metrics and Scoring Committee, organized under ORS 414.638, is responsible for and 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 annually.
- ~~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.~~
- (3) OHA and CMS shall have the right to request, and Contractor shall be required to provide, additional measures from time to time. Such additional measures may be used by for additional benchmarks or improvement targets or any other purpose permitted under this Contract.

d. OHA will review and analyze Contractor's Performance Data to determine compliance with Contractor's obligations with respect to access to care and services as required under this Contract and to determine eligibility for OHA incentive programs as set forth in Sub-Para. (1) of Para. a above of this Sec. 3, Ex. B, Part 10.

(1) In the event OHA determines, after reviewing Contractor's Performance Data, Contractor has failed to meet its performance obligations under this Contract, OHA shall have the right to require Contractor to submit additional Performance Data more frequently than otherwise required. Such additional Performance Data will be reviewed and analyzed by OHA to provide Contractor with timely feedback and determine whether Contractor must undertake certain activities to improve performance. OHA's remedy under this Sub. Para. (1), Para. d of this Sec. 3, Ex. B, Part 10 is in addition to all of OHA's other rights and remedies under this Contract.

~~(2) 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~~ Without limiting any other provision of this Contract, the Performance Measures reporting requirements set forth in this Ex. B, Part 10 expressly survive the expiration, termination, or amendment of this Contract, even if ~~Contract expiration, termination or such~~ amendment results in a ~~termination or modification of this Contract or a~~ modification or reduction of the Member Enrollment or Contractor's 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 each contract year are found at: <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.~~

~~i. By October 1 of each Year, OHA will issue the list of Quality Incentive measures and benchmarks, as well as the structure of the Quality Pool described in Section 13 of this Exhibit B, Part 9, (Quality Pool Methodology) for the subsequent year. These measures, benchmarks, and methodology will be used for the subsequent measurement year of the Quality Incentive Program. Payment for performance would be awarded from the Quality Pool in the year following the measurement year. For example, measures, benchmarks, and methodology document for 2020 will be published by October 1, 2019, and CCOs will receive payment for CY-2020 performance by June 30, 2021. All documentation will be made available online at <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.~~

~~9. Quality Performance Improvement Projects~~

4. Performance Measures: Quality Pool Incentive Payments

a. OHA has implemented a Quality Pool incentive payment program that is based on the outcome and Quality Measures adopted by the Metrics and Scoring Committee. The Quality Pool 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 adopted by the Metrics & Scoring Committee. The whole Quality Pool is at risk for performance. Total quality Payments in the aggregate by OHA are subject to a maximum percentage specified in the CCO capitation rate certification (see Exhibit C). The Quality Pool program does not alter any of

OHA's other rights under this Contract, including, without limitation, authority to administer the Encounter Data and quality reporting requirements.

b. Contractor will, if it meets certain metrics related to performance or improvement in a Measurement Year, receive a monetary Payment from the Quality Pool. Such metrics will be based on those selected by the Metrics and Scoring Committee and published by OHA, which publication will include additional specifications related thereto, for the applicable Measurement Year. In the event Contractor is entitled to receive a Quality Pool Payment, Contractor will be Paid such sum by June 30 during the Distribution Year immediately following the Measurement Year.

(1) For each Measurement Year Contractor will be measured against each 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, the Metrics & Scoring Committee may specify scoring on a tiered basis or on the basis of ability to report data. The Metrics & Scoring Committee also has the right to specify different methods of scoring, in which case Contractor will be provided with the different scoring methodology in the Quality Pool methodology documents published and posted by OHA at the URL identified in Para. c below of this Sec.4, Ex. B, Part 10.

c. OHA will publish the Quality Measures selected by the Metrics & Scoring Committee by October 1 of the year preceding the applicable Measurement Year. Additional specifications and criteria regarding such Quality Measures as well as benchmarks related thereto will be published approximately three months later but in no event by no later than December 31 immediately preceding the Measurement Year.

(1) The number and description of incentive Measures, their specifications and operationalization, are subject to change for future Measurement Years, at the discretion of the Metrics & Scoring Committee and subject to CMS approval.

(2) The structure of the Quality Pool, as well as additional instructions and information about the methodology for distributions from the Quality Pool will be posted by November 30 of the Measurement Year.

(3) Such Quality Measures, benchmarks required to be met in order to be eligible for Quality Pool incentive Payments, scoring methodology, and instructions and information for each Measurement Year are and will be located at:
<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>

(4) In the event a Measure eligible for a Quality Pool incentive Payment relates to claims for dates of service within a Measurement Year, CCOs, including Contractor shall have up to and through the end of last Business Day of March of the Distribution Year to submit such Performance Data to OHA for inclusion in the incentive Measures calculation. Any and all Performance Data relating to claims for dates of service in a Measurement Year submitted to OHA after the last Business Day of March of the Distribution Year will not be included in the incentive Measure calculation.

d. The funds from the Quality Pool that will be available for distribution to those CCOs eligible for Quality Pool incentive Payments for a Measurement Year will be at least the sum of two percent (2 %) of the aggregate of all 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 Contract Year. Final determination of the Quality Pool size will be published in the Reference Instructions.

- (1) The entire Quality Pool will be disbursed annually to CCOs by June 30 of the Distribution Year.
 - (2) Quality Pool distributions will be based on the Contractor's scores for Incentive Measures identified by the Metrics & Scoring Committee. The scoring shall be based on OHA's calculation and validation of Contractor's performance on each of the Incentive Measures.
 - (3) 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 31 of the Distribution Year to review and comment on final Incentive Measure calculations for the preceding Measurement Year.
 - (4) OHA will also evaluate any money left after Quality Pool distributions have been made for the Measurement Year and, at OHA's discretion, OHA may create a separate pool called the Challenge Pool to further incentivize CCO quality performance. Contractor will be eligible for the Challenge Pool award if Contractor passes specific Challenge Pool measures identified by the Metrics & Scoring Committee.
- e. ~~a.~~ Contractor shall ~~have an~~ create a written distribution plan for Quality Pool and Challenge Pool earnings.
- (1) The distribution plan must include:
 - (a) An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to the Contractor's process of evaluating the contributions of Participating Providers and connecting those evaluations to distribution of funds;
 - (b) Data on the expenditure of quality incentive pool earnings and whether the distribution considers payments made previously to Participating Providers (such as up front funding to a clinic or non-clinical partner that is intended to help the Contractor achieve metrics related to the Quality pool); and
 - (c) Information to help Participating Providers (including SDOH-E and public health partners) understand how they may qualify for payments, how Contractor distributed funds in the most recent year, and how they may distribute funds in future years.
 - (2) The distribution plan, should be provided to OHA via Administrative Notice and made publicly available each year within sixty (60) days of the Contractor's receipt of its final Quality Pool distribution.
- f. Prior Measurement Years data are available online at <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx>

5. Performance Measure Incentive Payments for Participating Providers

Contractor must offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Health-Related services Providers as appropriate), 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's Contract Administrator via Administrative Notice. Such arrangements and amounts paid shall be broken down by quarter and provided in an annual report in a format determined by OHA (about which OHA shall advise Contractor's Contract Administrator via Administrative Notice) and sent to OHA in conjunction with the 4th Quarter reporting period.

6. Performance Improvement Projects

a. In accordance with the State's 1115 Waiver and 42 CFR §438.330(d), Contractor shall ongoing create and implement a program of ~~performance improvement projects (PIPs)~~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 improve 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~~undertake PIPs that address at least four (4) of the ~~following 7~~eight (8) focus areas. ~~Contractor shall participate~~ listed below in this Para. b, Sec. 5, Ex. B, Part 10. One of the four shall be the Statewide PIP identified in focus area Sub. Para. (4), below, as a statewide PIP, of this Para. b, Sec. 5, Ex. B, Part 10. In order to satisfy the requirements set forth in 42 CFR §438.358 and 438.330(a)(2) Contractor shall select an additional ~~2 projects~~three (3) PIPs from the list ~~below, to serve as the Contractor's Performance Improvement Projects in accordance with 42 CFR §438.358 and 438.330(a)(2). Contractor shall cover the 4th of 7 focus areas through a focus study project. 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 and the Contractor's Quality and Transformation Strategy to the extent feasible.~~as follows:

- (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 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, behavioral care and/or ~~oral health~~Oral Health,
- (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, and
- (8) Social Determinants of Health and ~~Health~~ Equity.
- 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, CMS, in consultation with OHA and other stakeholders, may direct OHA to require Contractor, pursuant to the terms and conditions of this Contract, to meet specific performance measures and additional or different PIP focus areas.~~
- d. Within thirty-five (35) days of undertaking any PIP, Contractor must submit its proposed PIPs to OHA, via Administrative Notice, for review and approval. In the event any or all of Contractor's PIPs are not approved by OHA for failure to comply with the requirements set forth in the State 1115 Waiver, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract. Contractor shall submit its proposed PIPs using the PIP Notification Form located at the following URL:
<https://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Improvement.aspx>
- (1) Upon completion of a PIP, Contractor shall identify and undertake a new PIP and provide OHA with Administrative Notice, using the PIP Notification Form, of such new PIP
- e. ~~d.~~ Contractor must report the provide OHA, via Administrative Notice, with quarterly status and results of reports for each project quarterly to OHA. Reports of its four (4) PIPs. Quarterly status reports are due on April 30, July 31, October 31 and January 31 for the preceding calendar quarter work of each Contract Year. Such quarterly reports shall be made using the PIP progress report template located at:

~~10.—~~ **Program Requirements**

~~Contractor shall report to OHA Health Promotion and Disease Prevention Activities any national accreditation organization results and HEDIS measures, if applicable to Contractor or an Affiliate as required by the Department of Consumer and Business Services (DCBS) in OAR 836-053-1170. A copy of the reports may be provided to the OHA Performance Improvement Coordinator concurrent with any submission to DCBS.~~

<https://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Improvement.aspx>

- (1) In the event OHA determines a PIP is not resulting in sustainable, significant improvement in clinical or non-clinical areas in health outcomes or Member satisfaction, OHA shall have the right to direct Contractor to cease such PIP and create and undertake a new PIP in its place.

7. Additional Health System Transformation Obligations

- a. Contractor shall, in accordance with OAR 410-141-3170, convene a TQS-QAPI Committee to oversee its TQS and related quality assurance performance improvement efforts. Contractor's TQS-QAPI Committee shall oversee and be responsible for Contractor's annual TQS and Monitoring quality assurance performance improvement and transformation strategies and activities which shall include, without limitation review and approval of the annual TQS and TQS Progress Report prior to submission to OHA. The TQS-QAPI Committee is in addition to, and different from, Contractor's Community Advisory Council required to be created under Ex. K of this Contract.

- b. Contractor shall also participate as a member of the OHA Quality and Health Outcomes Committee.

8. ~~11.~~ External Quality Review

- a. In conformance with 42 CFR§438.350 and §438.358, and 42 CFR §457.1250. Contractor shall ~~cooperate~~permit OHA and ~~shall require~~ its ~~Subcontractors and Participating Providers to cooperate with OHA by providing~~designees to have access to, ~~or provide OHA with, Contractor's~~ records and facilities, and ~~sufficient~~ information requested by OHA and its designees, for the purpose of an annual ~~external, independent professional review~~External Quality Review of ~~CCO~~Contractor's compliance with all ~~applicable state and federal rules, the CCO contract with OHA and of~~Applicable Laws and this Contract as well as the quality outcomes and timeliness of, and access to, ~~Services~~services provided under this Contract.
- b. ~~If OHA or~~ 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 perform the annual EQR as determined by OHA. In the event OHA designates an EQRO to perform the EQR, OHA will~~ report ~~the findings to OHA and Contractor.~~
- ~~e.~~ ~~Consistent~~EQRO meets the criteria set forth in 42 CFR§ 438.354. In addition, OHA will, in accordance with 42 CFR§~~438.10~~438.310 and §438.350, ~~OHA will also do, in connection with the EQR, all of the following:~~
- (1) Implement an EQR protocol ~~following that complies with~~ CMS protocols required by 42 CFR §438.352 and provide such protocols to Contractor, prior to ~~review conducted of Contractor, and the EQRO follow that protocol~~the EQR;
 - (2) Provide information previously received from Contractor to the EQRO in an effort to reduce Contractor's duplicative submissions as directed by 42 CFR §438.360;
 - (3) ~~Require EQRO to meet competence and independence requirement in 42 CFR §438.354; and~~
- ~~e.~~ ~~Require an~~the EQRO to produce ~~the~~a report and information required ~~by~~under 42 CFR §438.364 and to ~~promptly~~ provide such information to Contractor ~~when complete.~~promptly after completion; and
- (4) ~~f.~~ Ensure that EQR results are made available, as required in 42 CFR §438.364, in an annual detailed technical report that summarizes findings on access and quality of care. ~~The most recent copy of the annual EQR technical report will be posted on OHA Web site as required under 42 CFR §438.10(c)(3) by April 30th of each year and provide printed or electronic copies, upon request.~~
- c. ~~(1)~~ Consistent with 42 CFR §438.350, §438.358, and §457.1250 the EQRO or OHA will:
- ~~(a)~~ ~~Conduct EQR of CCOs contracted with the State for the delivery of services covered under Medicaid.~~
 - (1) ~~(b)~~ Perform an EQR in a manner consistent with protocols established by CMS, which shall include, at a minimum, the elements in 42 CFR §~~438.364(a)(2)(i) through (iv).~~
 - ~~(c)~~ ~~Mandatory activities, described in 42 CFR §438.358(b), will be assessed by the EQRO in a matter~~ consistent with protocols established by CMS, for each EQR element.

~~(d) Additional EQR activities, described in 42 CFR §438.358(e), shall be reviewed by the EQRO as negotiated by OHA and EQRO.~~

~~(e)~~

(2) Produce a report that includes, at a minimum, the elements in 42 CFR §348.364.

(3) EQR review is performed on a timeline will adhere and schedule designed to comply with CMS requirements under established in 42 CFR §438.358 and §438.346(c).

(4) (2) The EQRO may, at the OHA's direction, Provide technical guidance, or direct the EQRO to provide technical guidance to groups of CCOs as directed by OHA, to Contractor to assist them Contractor in conducting activities related to the mandatory and additional activities described in 42 CFR §438.358 that provide information for the EQR and the resulting EQR technical report.

~~(3) Contractor shall address and require its subcontractors or delegated entities to address any findings or recommendations identified in EQR reports in a manner designed to correct the deficiency within a timeline acceptable to OHA.~~

~~12. 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 percentage specified in the CCO capitation rate certification (see Exhibit C). 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 measures selected by the Metrics & Scoring Committee and specifications published by OHA 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. 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.~~

d. All annual EQR technical reports will be posted on OHA website by April 30th of each calendar year.

e. ~~Metrics~~If an EQRO performs the EQR and identifies an adverse clinical situation in which follow-up is needed in order to determine whether appropriate care was provided, the EQRO will report the findings to OHA and Contractor. Regardless of whether OHA or an EQRO performs the review, Contractor shall promptly investigate and take action to remedy such adverse clinical situation.

~~(1) — For the eighth Measurement Year (CY 2020), CCO performance is based on XX Incentive Measures, specified at <http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx> Measure specifications and methodology for the fourth Measurement Year (CY2020) will be documented at <http://www.oregon.gov/oha/HPA/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~~Contractor shall provide evidence of resolution of all EQR findings to the EQRO or OHA as applicable. The EQRO or OHA, as applicable will make final determination of finding resolution. If Contractor fails to resolve findings and provide evidence of resolution within timeline established by OHA, or has identical recurrent finding in subsequent review by the EQRO such failure or recurrence shall constitute a breach of this Contract.

~~(1) — CCOs will be rewarded for meeting the Incentive Measures.~~

~~(2) — Each Incentive Measure has certain criteria that Contractor must meet to achieve that Incentive Measure. OHA will annually publish an updated Quality Pool Methodology and measure specifications with the criteria needed to quality on a given measure at <https://www.oregon.gov/OHA/HPA/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 will be based on the Contractor's scores for Incentive Measures identified by the Metrics & Scoring Committee.~~

~~(2) — OHA will also evaluate money left after the quality pool distribution and create a separate pool called the Challenge Pool to further incentivize CCO quality performance. Contractor will be eligible for the Challenge Pool award if it passes specific Challenge Pool measures identified by the Metrics & Scoring Committee. Challenge Pool is an incentive arrangement above the CCO capitation rate and will be reported separately in the Exhibit L financial report.~~

~~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:~~

~~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 clinical measures per requirements of this Contract; and~~

~~(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 the last business day of March of the Distribution Year. Claims and data for Dates of Service in a Measurement Year submitted to OHA after the last business day of March 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 31 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 (including Social Determinants of Health & Health Equity partners, public health partners, and other health related services providers as appropriate), 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/metrics/pages/HST-Reports.aspx>.~~

~~k. Contractor shall create a distribution plan for Quality Pool and Challenge Pool earnings. The plan should include:~~

~~(1) an overview of the methodology and/or strategy used to distribute quality pool earnings to participating providers, including Social Determinants of Health and Health Equity (SDOH-HE) and public health partners, that provides information related to the contractor's process of evaluating the contributions of participating providers and connecting those evaluations to distribution of funds; —~~

~~(2) data on the expenditure of quality incentive pool earnings and whether the distribution considers payments made previously to participating providers (such as up front funding to a clinic or non-clinical partner that is intended to help the contractor achieve metrics related to the quality pool);—~~

~~(3) information to help participating providers (including SDOH-HE and public health partners) understand how they may qualify for payments, how contractor distributed funds in the most recent year, and how they may distribute funds in future years.—~~

- ~~I. The distribution plan, should be provided to OHA and made publicly available each year within 60 days of the contractor's receipt of its final quality pool distribution.~~

[Remainder of page intentionally left blank]

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~~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 and Taxes." OHA ~~withholds~~will withhold a portion of the capitation as part of the Quality ~~Incentive~~Pool program (~~Exhibit~~See S. 12, Ex. B-Part 10), which is paid separately based on quality metrics achieved. OHA will prorate the CCO Payment for Members who are enrolled or disenrolled mid-month. OHA may withhold ~~payment~~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.~~Imposes suspension or denial of Payments as a Sanction under Ex. B, Part 9, Sec. 3, Para. b.
- b. The monthly CCO ~~Payment may include risk adjustment based on diagnosis or health status and will include a risk corridor in accordance with Section 6 of this Exhibit C.~~Payments for Contract Year one (2020) will reflect an increased margin to account for the increase in risk associated with various new policy objectives under this Contract. In Contract Year two (2021), OHA will again increase the margin allocated to the monthly CCO Payment. The amount of any increase in margin for Contract Years one and two shall be dependent on both the availability of funds within (i) the Medicaid growth cap, and (ii) OHA's budget as determined by its Director.
- (1) However, any such increase in Contract Year two (2021) shall be subject to a Withhold and will only be paid to Contractor if and when Contractor demonstrates it has complied with BUILD Fund spending requirements in Contract Year one (2020) and the first quarter of Contract Year two (2021). Contractor shall demonstrate its compliance with its BUILD Fund spending requirements by providing OHA with its annual audited financial statement for Contract Year one and submission of its first quarter Exhibit L Financial Report in accordance with Sec. 2, Paras. b and c of Ex. L of this Contract. In the event Contractor demonstrates compliance with its BUILD Fund spending plan, OHA will pay Contractor such Withheld margin increase attributable to the first six months of Contract Year by no later than the end of the third quarter of Contract Year two. The remaining margin increase will be paid out, at the same time CCO Payments are made, to Contractor in equal amounts over the remaining last quarter of the Contract Year.
- (2) In no event shall Contractor be eligible to benefit from or receive any Withheld amounts for Contract Year two (2021) if Contractor does not submit its spending plan as required under Sections 8 of Exhibit K or does not spend down all the funds in accordance with its BUILD Fund spending plan. In addition, failure to submit a BUILD Fund spending plan or spend down funds in accordance with its BUILD Fund spending plan in Contract Year one (2020) or Contract Year two (2021) may preclude Contractor's participation in financial or other reward programs that may be implemented in subsequent Contract Years.
- c. ~~In addition to the CCO Payment rate paid to Contractor, Contractor shall make qualified directed payment to hospital for the amounts indicated in a monthly report created by OHA to assist Contractors in distributing Quality and Access funds to the appropriate hospital. The monthly~~

CCO Payment may include risk adjustment based on diagnosis or health status and will reflect a risk corridor in accordance with S. 6 below of this Ex. C.

- d.** In addition to the CCO Payment Rate paid to Contractor, OHA will send Contractor Qualified Directed Payments (QDPs), which will include an amount to be paid by the Contractor to Hospitals per OAR 410-125-0230 plus an amount to be retained by the Contractor to cover the cost of administering managed care taxes. Contractor shall make QDPs to Hospitals in the amounts indicated in a monthly report created by OHA to assist Contractor in distributing Quality and Access funds to the appropriate Hospital. Contractor shall submit electronic payment to an account established by the Hospital within five (5) Business Days after receipt of the monthly report. If an error is identified in the monthly report, the Contractor shall make the payment based on the original amount provided in the report. OHA will identify separately the correction in the following month's report and adjust the total payment amount to account for the error.
- e.** ~~d.~~ As described in OAR 410-141-3420(10)-(12)-(14), 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 such a Hospital from mutually agreeing to reimbursement arrangements.
- f.** ~~e.~~ 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 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.~~
- g.** All Payments are subject to CMS approval.

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~~will ensure that no ~~payment~~Payment is made to a ~~provider~~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~~Sec. 22, Section 20 of this Contract~~Ex. D.~~

- 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 Sec. 14, 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 in effect on the date this Contract is executed, subject to the terms of this Contract. Changes in the Prioritized List may result in changes in CCO Payment Rates, as follows:

- (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~~will obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session.
- (4) If legislative scheduling permits, OHA will ~~notify~~provide Contractor Administrative Notice to Contractor's Contract Administrator at least two weeks prior to any legislative consideration of such reductions in Covered Services pursuant to ORS 414.735(3).
- (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~~Sec. 22, ~~Section 20~~Ex. D of this Contract.
 - (d) ~~The OHA will make available to Contractor 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 P, b, SP (1) through SP(5) of this S. 3., Ex. C~~ do not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.
 - ~~c.~~ e. This ~~paragraph~~Section 3 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~~Payment. If such change increases the CCO Payment owed by OHA to Contractor, then OHA will make a ~~payment~~Payment to Contractor, by one-time adjustment to a future regularly scheduled Capitation Payment or by separate ~~payment~~Payment. If such change decreases the CCO Payment owed by OHA to Contractor, then ~~such decrease~~any amount paid to

Contractor in excess of the decreased amount will be subject to ~~the recovery under S. 7, Ex. D~~
and any other applicable provisions of this Contract governing ~~overpayments~~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 eleventh (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~~will be made available to Contractor by the tenth (10th) day of the month to which such ~~payments~~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~~Payments described in Subsection a, of this section ~~shall~~will 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~~provide OHA's Contract Administrator with Administrative Notice of such errors. 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~~Payments will be made to Contractor by the tenth (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~~Fee-for-~~service~~Service Clients are not entitled to be paid as CCO Payments. Fee-for-service claims for ~~payment~~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~~Payment. Billing and ~~payment~~Payment of all ~~fee~~Fee-for-~~service~~Service claims shall be pursuant to and under OAR Chapter 410, Division 120.

5. Settlement of Accounts

- a. If a Member is ~~disenrolled~~Disenrolled, any CCO Payments received by Contractor ~~after~~for the ~~effective date of Disenrollment~~period for which the Member was Disenrolled will be considered

- an ~~overpayment~~Overpayment and will be recouped by OHA under ~~Paragraph P.~~ f. below of this S. 5, Ex. C.
- b. OHA will have no obligation to make any ~~payments~~Payments to Contractor for any period(s) during which Contractor ~~fails to carry out any~~ is in breach of this Contract, to the terms of extent that sanctions imposed under this Contract include suspending or withholding Payments.
 - 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~~ the Parties will execute an amendment modifying the applicable provisions of the Contract. If Payments made starting on the effective date of the reduction of the Service Area or Enrollment, ~~may result in recovery limit exceed the amount of CCO~~ Payments to which Contractor was not entitled under the terms of this Contract amendment, OHA will have the right to recover any such Overpayments.
 - d. Any ~~payments~~Payments received by Contractor from OHA under this Contract, and any other payments received by Contractor from OHA, ~~or pursuant to any other contract, agreement, or otherwise, or received from~~ any other source, to which Contractor is not entitled under the terms of this Contract, shall be ~~considered~~deemed an ~~overpayment~~Overpayment and ~~may be recovered by OHA~~ will have the right to recover such Overpayment from Contractor in accordance with S. 7, Ex. D of this Contract.
 - e. OHA has the right to recover Sanctions imposed ~~that result in Recovery Amounts pursuant to Exhibit D, Section 33 through 36 of~~ the form of civil money penalties imposed under Ex. B, Part 9 of this Contract by Recouping such amounts in accordance with Ex. B, Part 9 Sec. 8 and Sec. 9 of Ex. D to this Contract ~~are subject to.~~
 - f. Any Overpayment or recovery ~~and may be recovered by OHA from Contractor~~ amount imposed under Ex.
 - ~~f.~~ ~~Any overpayment or Recovery Amount under Exhibit B-Part 9 or Ex. C of this Contract may be recovered by~~ ~~recoupment~~Recoupment from any future payments to which Contractor would otherwise be entitled from OHA, ~~or pursuant to the terms of a written agreement with OHA, or (in the absence of sufficient future payments or written agreement) by civil action to recover the amount. OHA may (e.g. set-off from amounts that may be owing to Contractor), without limitation or waiver of any legal rights. OHA will have the right to~~ withhold payments to Contractor for amounts ~~disputed in~~ good faith dispute and shall not be charged interest on any payments so withheld.
 - g. OHA will ~~recover~~Recoup from Contractor ~~payments~~Payments made to Contractor or amounts paid to ~~other~~ Providers for sterilizations and hysterectomies performed where the Contractor failed to meet the requirements of ~~Exhibit Ex. B, Part 2, Section S. 4(g), P. e.~~ of this Contract, the. The Recoupment amount of which will be calculated as follows:
 - (1) Contractor shall, within sixty (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~~forms or ~~certification~~certifications. OHA will ~~be permitted~~have the right 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 at issue the number of sterilizations and hysterectomies provided or authorized by Contractor or its Subcontractors that did not meet the requirements of ~~Exhibit~~Ex. B, ~~Part 2, Section~~S. 4(g), P. e of this Contract.
- (3) Sterilizations and hysterectomies that Contractor ~~denies~~denied for payment shall not be included in the ~~recoupment~~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~~Ex. B, ~~Part 12, Section 6,~~P. e 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~~Encounter Data.
- (6) The results of ~~Paragraph~~SP (4), of this ~~subsection~~P. g, S. 5, Ex. C will be totaled to determine the amount of Overpayment made to Contractor’s ~~overpayment~~ for hysterectomies and sterilizations subject to recovery pursuant to ~~Exhibit~~S. 7, Ex. C, Section 5, Subsection g, of this Contract .
- (7) The final results of the review and recovery calculation will be ~~conveyed~~provided to Contractor’s Contract Administrator via Administrative Notice in a timely manner within ninety (90) days of OHA determination. ~~of amounts owed and recovery shall be made in accordance with S. 7, Ex. D of this Contract.~~

~~OHA will notify Contractor of in advance of any recovery and will provide Contractor with an opportunity to appeal the recovery. Contractor may file a written objection within 14 days from the date of the notice, requesting an appeal and setting forth with specificity the grounds for appeal. Any appeal shall be conducted as an administrative review. In such administrative review, 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. 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 recoveries. The decision on administrative review shall result in a final Recovery Amount if an appeal was timely filed.~~

~~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~~Corridors

~~a.~~ Operation of the CCO Risk Corridor

Contractor shall comply with the requirements for administration of the risk ~~corridor~~corridors established in this Section. The CCO Risk ~~Corridor utilizes~~Corridors utilize 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 ~~Expenses~~expenses of Members receiving eligible services ~~during the Risk Corridor Period~~, subject to settlement.

a. ~~(1)~~ Hepatitis C DAA Settlements.

(1) ~~(a)~~ Treatment of 340B ~~utilization~~Drug Utilization. Contractor shall reimburse all Hepatitis C DAA drugs that are purchased by a 340B ~~entity~~Entity at the 340B ~~entity~~Entity's actual acquisition cost, plus the ~~contractor~~Contractor's usual allowed dispensing fee. This requirement shall apply to 340B ~~drugs~~Drugs that are directly dispensed by a 340B ~~entity~~Entity, as well as 340B ~~drugs~~Drugs dispensed on contract by a non-340B ~~entity~~Entity.

(2) ~~(b)~~ Completion of Data Submissions. ~~Encounter Data for the~~The period from January 1, 2020 through December 31, 2020 ~~(12 months)~~, is the “Hepatitis C Risk Corridor Period.” ~~Encounter Data for the Hepatitis C Risk Corridor Period~~ must be submitted to OHA no later than April 30, 2021. Contractor shall ~~submit the following information~~Submit to OHA for Members receiving Hepatitis C DAA drugs for dates of service during the Hepatitis C Risk Corridor Period the following information:

(a) ~~(i)~~ Timely and accurate Encounter Data for all Hepatitis C DAA drugs.

(b) ~~(ii)~~ A form specified by OHA, ~~accompanied by an attestation that the following attestations:~~

i. That all Hepatitis C DAA ~~drugs~~Drugs that are 340B ~~drugs~~Drugs were reimbursed at the 340B ~~entity~~Entity's actual acquisition cost, plus the ~~contractor~~Contractor's usual allowed dispensing fee. Any such drugs found to be in conflict with this requirement will be repriced at the 340B ~~ceiling price~~Ceiling Price, if reported cost is higher.

~~Safe harbor for 340B pricing. OHA will not reprice 340B drugs covered by a Contractor if the aggregate paid amount for such claims total 55% or less than the full Wholesale Acquisition Cost (WAC) at the time of dispensing.~~

ii. ~~(iii)~~ A form specified by OHA, ~~accompanied by an attestation that~~That any restrictive drug list (as described in OAR 410-141-3070(3)) will, at a minimum, include the Hepatitis C DAA drugs included on the OHA-approved ~~fee~~Fee-for-service ~~(“FFS”)~~Service Preferred Drug List (also known as the practitioner managed prescription drug plan ~~or “PMPDP”~~). Contractor may continue to prefer additional Hepatitis C DAA drugs, so long as doing so does not conflict with any Statewide Supplemental Rebate Agreement entered into by OHA. Any drugs found to be in conflict with a Statewide Supplemental Rebate Agreement included in the Contractor's Hepatitis C DAA data will be repriced as if the FFS preferred drug were used (net of rebates), if reported cost is higher.

- ~~iii. (iv)~~ ~~A form specified by OHA, accompanied by an attestation that~~That all Members eligible for, and who received, Hepatitis C DAA drugs followed the same criteria and ~~prior authorization~~Prior Authorization protocol as specified in the OHA-approved coverage criteria for FFS ~~members~~Members. The FFS criteria do not apply when Medicaid is the secondary payer. Contractor may specify alternative criteria for non-preferred PMPDP Hepatitis C DAA ~~drugs~~Drugs, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.
- ~~iv. (v)~~ ~~A form specified by OHA, containing an attestation completed by Contractor that~~That Contractor has not received and will not seek conflicting supplemental rebates for Hepatitis C DAA ~~drugs~~Drugs dispensed during the Hepatitis C Risk Corridor Period. In the same form, Contractor shall also report any ~~offsets~~Offsets as it relates to Hepatitis C DAA ~~Expenses~~expenses. Contractor may continue to collect supplemental rebates for Hepatitis C DAA ~~drugs~~Drugs, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.
- ~~v. (vi)~~ ~~A form specified by OHA, containing an attestation completed by Contractor detailing~~Details of the care management protocol for each Member receiving DAA ~~drugs~~Drugs for treatment of Hepatitis C. ~~Prior to commencement of the Hepatitis C Risk Corridor Period,~~ OHA will consult with the Coordinated Care Organizations to develop a definition for “adequate care management.” The definition will be posted to the CCO Contract Reports Web Site~~Forms Website~~, prior to January 1, 2020.

- ~~(3)~~ ~~(e)~~ OHA will compare the Hepatitis C Expenses using the paid amounts reported on the Encounter Data. OHA may request additional information if needed for clarification, or if any encounters have a zero paid amounts. A settlement report in a form prepared by OHA with information about the methodology will be sent to Contractor for Encounter Data validation purposes.
- ~~(4)~~ ~~(d)~~ Hepatitis C DAA Expenses will be compared with Hepatitis C DAA Revenue.
- ~~(5)~~ ~~(e)~~ Hepatitis C DAA Admin Revenue will be evaluated against Contractor’s care management protocol contained in the form referenced above. Contractor will be required to return a portion of the Hepatitis C DAA Admin Revenue to OHA if OHA determines, ~~in its sole discretion,~~ that Contractor failed to perform adequate care management for Hepatitis C DAA Drugs.
- ~~(6)~~ ~~(f)~~ The outcome of this settlement process will be used to determine whether OHA owes a ~~payment~~Payment to the Contractor or the Contractor owes a payment to OHA.
- ~~(7)~~ Safe Harbor for 340B Drug Pricing. OHA will not reprice 340B Drugs covered by a Contractor if the aggregate paid amount for such claims total 55% or less than the full Wholesale Acquisition Cost at the time of dispensing.

~~b. (2)~~ Hepatitis C Risk Corridor Payments.

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

~~(a)~~ ~~(i)~~ When Contractor's Hepatitis C DAA Expenses for the Hepatitis C Risk Corridor Period are equal to or greater than 105 percent of the Hepatitis C DAA Revenue, OHA will pay Contractor an amount equal to 100 percent of Hepatitis C DAA Expenses in excess of 105 percent of the Hepatitis C Revenue.

~~(2)~~ ~~(b)~~ Contractor will owe payments to OHA in the following amounts under the following circumstances:

~~(a)~~ ~~(i)~~ When Contractor's Hepatitis C DAA Expenses for the Hepatitis C Risk Corridor Period are less than, or equal to, 95 percent of the Hepatitis C DAA Revenue, the Contractor shall owe OHA an amount equal to 100 percent of the difference between the Contractor's Hepatitis C Expenses and 95 percent of the Hepatitis C DAA Revenue.

~~(3)~~ ~~(e)~~ OHA will, after conferring with the Contractor about the method and timing of the ~~payment~~Payment or ~~charge~~Charge, make the ~~payment~~Payment to Contractor or require a payment from Contractor by adjusting future ~~payments to Contractor~~.

~~(3)~~ ~~Initial Procurement Risk Corridor Settlements:~~

~~(a)~~ ~~Completion of data submissions. Encounter data for the period from January 1, 2020 through June 30, 2020 (6 months), must be submitted to OHA no later than December 31, 2020. Contractor shall submit timely and accurate encounter data to OHA.~~

~~(b)~~ ~~OHA will compare the medical expenses using the encounter data. OHA may request additional information if needed for clarification. A settlement report in a form prepared by OHA with information about the methodology will be sent to Contractor for encounter data validation purposes. The settlement process is further described in OHA's Initial Procurement Risk Corridor Implementation Policy and Procedures available on the CCO Contract Reports Web Site.~~

~~(c)~~ ~~Initial procurement expense will be compared with Initial procurement revenue.~~

~~(d)~~ ~~The outcome of this process will be used to determine whether OHA owes a payment to the Contractor or the Contractor owes a payment to OHA.~~

~~(4)~~ ~~Initial Procurement Risk Corridor Payments~~

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

~~(i)~~ ~~When Contractor's Initial Procurement Expense for the Initial Procurement Risk Corridor Period is between 102 percent and 105 percent of the Initial Procurement Revenue, OHA will pay Contractor an amount equal to 50 percent of the Initial Procurement Expense between 102 percent and 105 percent of the Initial Procurement Revenue; or~~

~~(ii)~~ ~~When Contractor's Initial Procurement Expense for the Initial Procurement Risk Corridor Period is equal to or greater than 105 percent of the Initial~~

~~Procurement Revenue, OHA will pay Contractor an amount equal to 75 percent of Initial Procurement Expense in excess of 105 percent of the Initial Procurement Revenue, and 50 percent of Initial Procurement Expense between 102 percent and 105 percent of Initial Procurement Revenue.—~~

- ~~(b) OHA will charge Contractor in the following amounts under the following circumstances:~~
- ~~(i) When Contractor's Initial Procurement Expense for the Initial Procurement Risk Corridor Period are between 95 percent and 98 percent of the Initial Procurement Revenue, OHA will charge the Contractor an amount equal to 50 percent of the excess between 95 percent of the Initial Procurement Revenue and the Initial Procurement Expense; or~~
 - ~~(ii) When Contractor's Initial Procurement Expense for the Initial Procurement Risk Corridor Period are less than, or equal to, 95 percent of the Initial Procurement Revenue, the OHA will charge the Contractor an amount equal to 75 percent of the difference between the Contractor's Initial Procurement Expense and 95 percent of the Initial Procurement Revenue; and the Contractor shall owe OHA 50 percent of Initial Procurement Revenue between the 95 percent and 98 percent corridor.—~~
- ~~(e) OHA will, after conferring with the Contractor about the method and timing of the payment or charge, make the payment to Contractor or require a payment from Contractor by adjusting future payments to Contractor.~~

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 CY20 – 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 Penalty

With implementation of the Administrative Performance (AP) Standard, OHA utilizes an AP Penalty APP methodology in accordance with ~~Exhibit Ex. B, Part 8, Section 7S.d.9.~~

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. In accordance with ~~CMS~~ 42 CFR §438.8 Contractor shall maintain a Minimum Medical Loss Ratio (~~MMLR~~) of at least 85% for its total Member population and shall ~~submit~~Submit, as set forth in Paragraphs c. and d. below of this Section, an annual, certified MMLR Rebate Report which validates its compliance with this requirement.

- b. Contractor shall meet or exceed the MMLR Standard for each Rebate Period. In the event Contractor's MMLR falls below the MMLR Standard for a Rebate Period, Contractor shall be obligated to OHA for a Rebate.
- c. Contractor shall ~~file~~Submit its MMLR Rebate Report electronically utilizing the Minimum Medical Loss Ratio Rebate Calculation template (Excel Workbook) and following the Minimum Medical Loss Ratio Rebate Calculation Report Instructions located on the ~~CCO Contract Reports Web Site~~Forms Website as well as in accordance with CMS Rules 42 CFR §438.8 Medical Loss Ratio (~~MMLR~~). All information reported on the MMLR Rebate Report must be for revenues and expenses under this Contract or a predecessor CCO contract of Contractor's. The MMLR Rebate Report must be certified by an officer of Contractor, under penalty of ~~false claims act~~the Oregon False Claims Act liability, in the manner required by the Minimum Medical Loss Ratio Rebate Calculation Report Instructions.
- d. Contractor shall ~~file~~Submit its MMLR Rebate Report for each Reporting Period with OHA's Contract Administration Unit each year by June 30 of the year following the Reporting Period based on OHA's instructions and provided template(s).
- e. OHA will review Contractor's filed MMLR Rebate Report as follows;
- (1) If OHA determines that Contractor's MMLR Rebate 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 Rebate Period.
 - (2) If OHA determines that Contractor's MMLR Rebate Report is incomplete or inaccurate, OHA will provide or request proposed revisions to the MMLR Rebate Report. Contractor shall supply any information requested by OHA in connection with the MMLR Rebate Report within ten (10) Business Days of the request. The revised MMLR Rebate Report will become final for purposes of the MMLR calculations ten (10) Business Days after the date of the revisions, unless OHA's Contract Administrator receives, via Administrative Notice, from Contractor a written notice of appeal for the applicable Reporting Period not later than ten (10) Business Days after the date of the revisions. The ~~notice~~Legal 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~~Administrative Review process will be conducted in the manner described in OAR 410-120-1580(3)-(6). Contractor understands and agrees that ~~administrative review~~Administrative Review is the sole avenue for review of the MMLR Rebate Reports that it has appealed. The decision on ~~administrative review~~Administrative Review will result in a final MMLR Rebate Report if an appeal was timely filed.
 - (4) OHA will rely upon the final MMLR Rebate Report to determine whether the Contractor is subject to a Rebate for the Rebate 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 December 31, via Administrative Notice to Contractor's Contract Administrator, of the year in which the MMLR Rebate Report is filed.
- f. 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~~may be ~~offset~~Offset against future CCO Payments or otherwise recovered in accordance with Sec. 7, Ex. D of this Contract.

[Remainder of page intentionally left blank]

Exhibit C – Consideration - Attachment 1 – CCO Payment Rates

This Attachment 1 includes all CCO rate types. The following table reflects which rate types apply to this Contract.

For the period of January 1, 2020 through December 31, 2020 the following rates apply:

Rate Type
CCO A - All Services
CCO B – Physical Health and Behavioral Health Services
CCO E – Behavioral Health Services Only
CCO G – Behavioral Health and Dental Health Services Only

(Specific Plan Rates are set forth in Attachment 1 to Exhibit C, [attached at the end of this Contract](#))

[\[Remainder of page intentionally left blank\]](#)

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~~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 or of Multnomah County for the State of Oregon; provided, however, (a) if federal jurisdiction exists then OHA may remove the ~~claim~~Claim to federal court, and (b) if a ~~claim~~Claim must be brought in or is removed to 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~~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 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, Divisions 012, 014, 015, 018, 019, 022, 032 and 040, 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~~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~~Application related to this Contract, if any, independently from all other Contractors, 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)~~Correction of Deficient Documents. For all reports, policies and procedures, handbooks, materials, and any other documents required to be provided to OHA or other state or federal agency under this Contract for review and approval (for this Section 5, Ex. D only, the "Document(s)").

Contractor shall, unless expressly provided otherwise in this Contract, follow the process set forth below in this S. 5, Ex. D to resolve any disagreements in those instances when OHA disapproves of a Document:

- a. Upon determining a Document submitted by Contractor has failed to comply with the standards for approval of such Document, OHA will provide Contractor's Contract Administrator with Administrative Notice of such and identify: (i) the steps Contractor must take to remedy the deficiencies in the applicable Document, (ii) if not expressly stated otherwise in this Contract, the deadline for submitting the revised Document, and (iii) the means by which such revised Document shall be resubmitted for review and approval;
- b. Upon receipt of OHA's Administrative Notice in that a Document has not been approved by OHA, Contractor shall remedy the Document as directed by OHA;
- c. In the event Contractor fails to comply with OHA's directive to remedy the Document as directed by OHA, or upon resubmission to OHA for re-review and approval OHA again determines the Document fails meet the requirements set forth in this Contract, OHA will have to right to exercise all of its rights and remedies under Exhibit B- Part 9.

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~~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. Upon request, Contractor shall provide its taxpayer identification number ~~(TIN)~~—and other necessary banking information to receive EFT ~~payment~~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~~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~~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~~Payment under this Contract until receipt of the correct EFT designation and ~~payment~~Payment information from the Contractor.

7. Recovery of Overpayments or Other Amounts Owed by Contractor

- a. **IF ~~PAYMENTS~~PAYMENTS UNDER THIS CONTRACT, OR UNDER ANY OTHER CONTRACT BETWEEN CONTRACTOR AND OHA, RESULT IN ~~PAYMENTS~~PAYMENTS TO CONTRACTOR TO WHICH CONTRACTOR IS NOT ENTITLED (I.E. OVERPAYMENT), OHA ~~MAY~~SHALL HAVE THE RIGHT TO PURSUE A RECOVERY, FOLLOWING THE PROCEDURES IN EXHIBIT C SECTION 5 (SETTLEMENT OF ACCOUNTS). FOLLOWING EXHAUSTION OF THE ADMINISTRATIVE PROCEDURES IN EXHIBIT C, SECTION 5, CONTRACTOR HEREBY REASSIGNS TO OHA ANY RIGHT CONTRACTOR MAY HAVE TO RECEIVE SUCH PAYMENTS. 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 OR ANY OTHER CIVIL REMEDY.

8. Indemnity

- a. **GENERAL INDEMNITY.** CONTRACTOR SHALL DEFEND, SAVE, HOLD HARMLESS, AND INDEMNIFY THE STATE OF OREGON AND OHA AND THEIR OFFICERS, EMPLOYEES ~~AND,~~ SUBCONTRACTORS, AGENTS, INSURERS, AND ATTORNEYS FROM AND AGAINST ALL OF THE FOLLOWING (HERE, "INDEMNIFIABLE EVENTS"): ALL CLAIMS, SUITS, ACTIONS, LOSSES, DAMAGES, LIABILITIES, SETTLEMENTS, COSTS AND EXPENSES OF ANY NATURE WHATSOEVER (INCLUDING REASONABLE ATTORNEYS' FEES AND EXPENSES AT TRIAL, AT MEDIATION, 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, INSURERS, AND ATTORNEYS (OR ANY COMBINATION OF THEM) UNDER THIS CONTRACT. INDEMNIFIABLE EVENTS INCLUDE, WITHOUT LIMITATION, (i) UNAUTHORIZED DISCLOSURE OF CONFIDENTIAL RECORDS OR INFORMATION OF MEMBERS, INCLUDING WITHOUT LIMITATION RECORDS AND INFORMATION PROTECTED BY HIPAA OR 42 CFR PART 2, (ii) ANY BREACH OF S. 6, EX. E, (iii) IMPERMISSIBLE DENIAL OF COVERED SERVICES, (iv) FAILURE TO COMPLY WITH ANY REPORTING OBLIGATIONS UNDER THIS CONTRACT, (v) FAILURE TO ENFORCE ANY OBLIGATION OF A SUBCONTRACTOR, AND (vi) SUBCONTRACTING PRECLUDED 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~~PARA. a., ABOVE OF THIS SEC.8, EX. D; 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 PRIOR WRITTEN APPROVAL 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 PRIOR WRITTEN 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.~~ THE STATE OF OREGON MAY, AT ITS OWN ELECTION AND EXPENSE ASSUME ITS OWN DEFENSE AND SETTLEMENT IN THE EVENT THE STATE OF OREGON DETERMINES 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~~NEGLIGENCE, WILLFUL, OR INTENTIONAL MISCONDUCT OF CONTRACTOR'S EMPLOYEES, SUBCONTRACTORS, OR AGENTS ~~OF CONTRACTOR.~~

d. WITHOUT LIMITING ANY OTHER PROVISION IN THIS CONTRACT, IN NO EVENT SHALL OHA BE LIABLE FOR: (i) PAYMENT FOR CONTRACTOR'S OR SUBCONTRACTOR'S DEBTS OR LIABILITIES REGARDLESS OF WHETHER SUCH LIABILITIES ARISE OUT OF SUCH PARTIES' INSOLVENCY OR BANKRUPTCY, (ii) COVERED SERVICES AUTHORIZED OR REQUIRED TO BE PROVIDED BY CONTRACTOR UNDER THIS CONTRACT, REGARDLESS OF WHETHER SUCH COVERED SERVICES WERE PROVIDED OR PERFORMED BY CONTRACTOR, CONTRACTOR'S SUBCONTRACTOR, OR CONTRACTOR'S PARTICIPATING OR NON-PARTICIPATING PROVIDER, OR (iii) BOTH (i) AND (ii) OF THIS PARA. D, SEC. 8, EX. D.

e. ~~d.~~—THE OBLIGATIONS OF THIS SECTION ~~98~~ ARE NOT SUBJECT TO THE ~~LIMITATIONS~~LIMITATION ON DAMAGES SET FORTH IN SECTION ~~H12~~ BELOW OF THIS EXHIBIT D.

9. 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 fourteen (14) days after receipt of OHA's ~~notice~~Legal Notice or such longer period as OHA may specify in such ~~notice; or~~Legal Notice; or
- (3) Contractor's fails to ensure that no cancellation, material change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) occurs without sixty (60) days prior written notice from Contractor or its insurer(s), which shall be made to OHA via Administrative Notice to ; or
- (4) ~~(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 fourteen (14) days after receipt of OHA's ~~notice~~Notice, or such longer period as OHA may specify in such ~~notice~~Notice; or
- (5) ~~(4)~~—Contractor knowingly has a director, officer, partner or person with beneficial ownership of five percent (5%) or more 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).
- ~~(6)~~ ~~(5)~~ If OHA determines that health or welfare of Members is in jeopardy if this Contract continues; or
- ~~(7)~~ ~~(6)~~ Contractor fails to enter into an amendment described in ~~Exhibit D, Paragraph 19b, Sec. 21, Para. b below of this Ex. D.~~, as necessary for the amendment to go into effect on its proposed effective date.
- ~~(8)~~ Any notice of default by Contractor must identify, with specificity, the term or terms of this Contract allegedly breached.
- b. **OHA's Remedies for Contractor's Default.** In the event Contractor is in default under ~~Section 10.a~~Sec. 9, Para. a, above of this Ex. D, 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)~~Sec. 9, Para. e, Sub. Para. (2) below of this Ex. D. 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, including civil monetary penalties if applicable, as permitted under Ex. B, Part 9,~~ 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~~Recoupment or Withholding of Overpayments under ~~Section~~Sec. 7 above of this ~~Exhibit~~Ex. D or ~~setoff~~Offset 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~~will 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~~Withholding or Recoupment for ~~overpayment~~Overpayment or other ~~offset~~Offset, and OHA fails to cure such failure within ~~fifteen (15-calendar)~~ days after ~~delivery~~receipt of Contractor's ~~notice~~Legal Notice of such failure to pay or such longer period as Contractor may specify in such ~~notice~~Legal 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 thirty (30) days after Contractor's ~~notice~~Legal Notice or such longer period as Contractor may specify in such ~~notice~~Legal 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. Sec.9, Para. c. above ~~and whether or not Contractor elects to exercise its right to of this Ex. D,~~ terminate ~~this Contract under Section 10.e.(3) below,~~ Contractor's sole remedy shall be a ~~Claim~~claim for any unpaid ~~CCO Payments or case rate or supplemental payments~~amounts then due and owing from OHA to Contractor, as identified in Exhibit C ~~less previous amounts paid and any claim(s) that OHA has against Contractor,~~ net of any Recoupment for Overpayment or other Offset . Except as may be expressly permitted under S. 8. P. c of this Ex. D., ~~damages recoverable by Contractor under this Contract shall be limited as provided for in Section 12 below of this Exhibit D.~~ In no event shall OHA be liable to Contractor for any expenses Contractor incurs that arise out of or are 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.

f. **Termination**

- (1) OHA's ~~Right~~right to ~~Terminate~~terminate at its Discretion. At its sole discretion and without liability to Contractor, OHA may terminate this Contract:
- (a) Without cause upon one hundred and twenty (120)~~calendar~~ days' prior written ~~notice~~Legal Notice of termination by OHA to Contractor; or
 - (b) ~~Immediately upon~~Upon receipt of written ~~notice~~Legal Notice of termination or the effective date otherwise identified in such Legal 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~~Upon receipt of written ~~notice~~Legal Notice of termination or the effective date otherwise identified in such Legal 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~~products from the planned funding source; or
 - (d) ~~Immediately, and notwithstanding~~Notwithstanding any claim Contractor may have under Section 15, "Force Majeure," upon receipt of written ~~notice~~Legal Notice of termination to Contractor if ~~there is~~OHA determines that continuation of the Contract poses a threat to the health, safety, or welfare of any ~~Client~~Member, including any Medicaid eligible individual, under ~~its~~Contractor's care.
- (2) OHA's Right to ~~Terminate~~terminate for Cause. In addition to any other rights and remedies OHA may have under this Contract, and subject to ~~Section 10.e.~~Sec. 9, Para. e., SP (3) below of this Ex. D, OHA ~~shall~~will have the right, at its sole discretion and without liability to Contractor, to issue ~~notice~~Legal 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)~~Sec. 9, Para. a, Sub. Para. (1) above of this Ex. D because Contractor ~~institutes~~has instituted or has had 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.~~Sec. 9, Para. a., Sub. Para. (2) above of this Ex. D 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.~~Sec. 9, Para. a., Sub. Para. (3) above of this Ex. D 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~~Terminating this Contract under ~~Section 10.e.~~this Sec. 9, Para. e., Sub. Para. (1) or Sub. Para. (2) above of this Exhibit D, OHA will:
- (a) Provide Contractor an opportunity to ~~appeal the notice of request~~request Administrative Review of the Legal Notice of termination or Legal Notice of OHA's intent to terminate pursuant to OAR 410-120-1560 and 410-120-1580. In the event that no appeal process is available to Contractor under OAR 410-120-1560, then If no Administrative Review is requested, or following the Administrative Review and any appeals thereof the Contract shall be terminated in accordance with the Legal Notice of termination~~notice~~. Where termination is based on failure to comply with a Corrective Action and Contractor has already had an Administrative Review on issues substantially similar to the basis for the proposed termination~~decision~~, such Administrative Review, subject to any appeal thereof, is deemed to satisfy any requirement for a pre-termination hearing; and
- (b) After ~~the hearing or~~ Administrative Review, give Contractor written ~~notice~~Legal 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~~has provided Contractor with Legal Notice that it has terminated its Contract under Sec. 9, Para. e., Sub. Para. (1) or intends to terminate ~~its~~this Contract under ~~Section 10.e.(1) or~~Sub. Para. (2), above of this Ex. D, OHA must give the affected Members written notice of OHA's intent to terminate this Contract and allow affected Members to ~~disenroll~~Disenroll immediately without cause.
- (4) Contractor's Right to ~~Terminate~~terminate for Cause. Contractor may terminate this Contract for cause if OHA is in default under ~~Section 10.e.~~Sec. 9, Para. c. above of this Ex. D and fails to cure such default within the time specified therein.
- (5) Contractor's Right to ~~Terminate~~terminate at its Discretion. No later than one hundred and thirty-four (134-calendar) days prior to the end of a ~~Benefit Period~~Contract Year, other than a ~~Benefit Period~~Contract Yea at the end of which this Contract will expire, OHA ~~shall~~will provide ~~to Contractor~~notice's Contract Administrator with Administrative Notice of the proposed changes to the terms and conditions of ~~the~~this Contract, ~~as that~~ will be submitted by OHA to CMS for approval; for the next ~~Benefit Period~~Contract Year. At its sole discretion, Contractor may terminate this Contract without cause by written ~~notice~~Legal Notice to OHA not later than one hundred and twenty (120-calendar) days prior to the effective date of any Renewal Contract, for termination effective ~~at~~as of the Renewal effective date. A refusal by Contractor to enter into a Renewal Contract terminates this Contract, regardless of whether ~~or not~~ Contractor provided the ~~notice~~Legal Notice described in ~~the previous sentence.~~this Sec. 9, Para.e. Sub. Para. (5) of this Ex. D.
- (6) ~~OHA may~~Notwithstanding Contractor's Legal Notice of termination or failure to enter into a Renewal under Sec. 9, Para. e., Sub. Para. (5) above of this Ex. D, OHA will have the

right to require the Contract to remain in full force and effect into the next ~~Benefit Period~~Contract Year and be amended as proposed by OHA until ninety (90-calendar) days after the Contractor has, in accordance with criteria prescribed by OHA: provided a Transition Plan in accordance with Sec. 10, Para. a below of this Ex. D.

~~(a) — Notified each of its Members and contracted Providers of the termination of the Contract;~~

~~(b) — Provided to OHA a plan to transition its Members to another Contractor; and~~

~~(c) — Provided to OHA a plan for closing out its business under this Contract.~~

- (7) OHA may waive compliance with the deadlines in ~~subsections~~Sub. Paras. (5) and (6) of this sectionSec. 9, Para. e., of this Ex. D if OHA finds that the waiver of the deadlines is consistent with the effective and efficient administration of the Medicaid program and the protection of Members. If Contractor does not execute a Renewal Contract or intends to not Renew, but fails to provide ~~notice~~Legal Notice of non-Renewal to OHA one hundred and twenty (120-calendar) days prior to the date of any Renewal Contract, OHA ~~may will~~ have the right to extend this Contract ~~at its discretion~~ for the period of time OHA considers necessary, in its sole discretion, to accomplish the termination planning described in this ~~Subsection e~~Sec. 9, Para. e., Sub. Para (6) of this Ex. D.
- (8) After receipt of the Contractor's ~~notification~~Notification of intent not to Renew, or upon an extension of this Contract as described in ~~the previous sentence~~Sub. Paras. (6) and (7) of this Sec. 9., Para. e. above of this Ex. D, OHA will issue written ~~notice~~Notice to the Contractor specifying the effective date of termination, Contractor's operational and reporting requirements, and timelines for submission of deliverables.
- (9) Mutual ~~Termination~~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.
- (10) Automatic ~~Termination~~termination. This Contract will ~~terminate~~ automatically be subject to termination under the condition described in ~~Exhibit C, Section 10. Sec. 9, Para. a. Sub. Para. (7) and Para. e Sub. Para. (6) above of this Ex. D. (refusal to enter into an amended contract.)~~
- (11) The party initiating the termination shall render written ~~notice~~Legal Notice of termination to the other party ~~by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination and~~ must specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination is proposed to become effective.

10. Effect of Legal Notice of Termination, Non-Renewal, or Failure to Renew: Transition Plan.

a. ~~(12)~~ After providing or receiving ~~notice~~Legal Notice of termination, or, in the case of expiration under Section 1 of the General Terms to this Contract, at least one hundred twenty (120) days before ~~expiration~~the Expiration Date of this Contract, Contractor shall:-

~~(a) —~~ Submit commence performing all of the Close-Out Requirements and Runout Activities set forth in this Secs. 10-11, Ex. D, and those set forth in OAR 410-141-3258, which includes Contractor drafting and providing to OHA, via Administrative Notice, with a Transition Plan ~~detailing.~~ For purposes of clarity,

any and all obligations required to be performed upon termination under this Section 10 of this Exhibit D, shall also be required to be performed upon expiration. Contractor's Transition Plan shall include without limitation:

- (1) Detail how Contractor will fulfill its continuing obligations under this Contract~~and identifying an individual, including, without limitation, operational and reporting requirements, submitting deliverables as required by OHA and OAR 410-141-3258;~~
 - (2) Identifying a Transition Coordinator (with ~~contract~~contact information) as ~~Contractor's transition coordinator.~~OHA's single point of contact for all issues related to Contractor's Transition Plan;
 - (3) A list identifying the prioritization of high-needs Members for Care Coordination and any other Members requiring high level coordination;
 - (4) How and when Contractor will notify its Members, Providers, and Subcontractors of the termination of this Contract:
 - (a) Contractor shall include in the notices sent to Members information relating to Continuity of Care and how Members will be transitioned from Contractor to a new CCO without any disruption to the provision of services;
- b.** The Transition Plan is subject to review and approval by OHA for compliance with Secs. 10 and 11 of this Ex. D. OHA shall provide Contractor's Transition Coordinator with notice of approval or disapproval via Administrative Notice. Contractor shall make revisions to the plan as necessary in order to obtain approval by OHA. Failure to submit a Transition Plan provide to, and obtain written from, OHA approval of the Transition Plan by shall give OHA may result in OHA extending the right to extend the termination date by the amount of time necessary in order for both OHA to approve the Transition Plan submitted by the Contractor's Transition Plan and for Contractor to carry out its obligations under such approved Transition Plan. ~~The~~
- c.** During the Transition Plan Period Contractor shall include the prioritization of high-needs Members for care coordination and any other Members requiring high level coordination.
- (b) ~~Submit~~ be required to provide to OHA status reports ~~to OHA~~ every thirty (30) ~~calendar~~ days detailing the Contractor's progress in carrying out the Transition Plan. ~~The~~ Contractor, shall submit its final status report to OHA describing shall describe how ~~the~~ Contractor has fulfilled all of its obligations under the Transition Plan including resolution of any outstanding responsibilities. During the Transition Period, Contractor shall, at a minimum, do all of the following:
 - (1) Continue to perform all financial, management, and administrative services obligations including the maintenance of restricted reserves and insurance coverage for a period of no less than eighteen (18) months following the effective date of termination, or until the State provides Contractor with Legal Notice that all obligations have been fulfilled, whichever is earlier.
 - (2) ~~(e)~~ Maintain adequate staffing to perform all functions specified in Contract.
 - (3) ~~(d)~~ Promptly supply all information requested by OHA for reimbursement of any claims outstanding at the time of termination.
 - (4) ~~(e)~~ Promptly make available any signed ~~provider~~ Provider agreements requested by OHA.

- (5) ~~(f)~~ Cooperate with OHA to arrange for orderly and timely transfer of Members from coverage under this Contract to coverage under new arrangements authorized by OHA. Such actions of cooperation shall include, but are not limited to Contractor:
- (a) ~~(1)~~ Forwarding of all records related to Members, including high-needs ~~care coordination~~Care Coordination;
 - (b) ~~(2)~~ Facilitating and scheduling of medically necessary arrangements or appointments for care and services, including arrangements or appointments with Contractor's network ~~providers~~Providers for dates of service after the Contract termination date~~;~~;
 - (c) ~~(3)~~ Identifying chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy~~;~~;
 - (d) ~~(4)~~ Continuing to provide ~~care coordination~~Care Coordination until appropriate transfer of care can be arranged for those Members in a course of treatment for which a change of Providers could be harmful~~;~~;
- (6) ~~(g)~~ Make available (including, as applicable, requiring its Providers and Subcontractors to make available), to OHA or another health plan to which OHA has assigned the Member, copies of medical, ~~behavioral, oral health and case care management~~Behavioral Health, Oral Health, and managed Long Term Services and Supports records, ~~Member~~patient files, and any other ~~pertinent information, including~~ information ~~maintained by any subcontractor, as OHA deems necessary for effective Care Management~~the efficient care management of Members as determined by OHA. Such records shall be in a ~~usable form~~format or formats directed by OHA and shall be provided at no expense to OHA or the Member, ~~using a file format and dates for transfer specified by OHA~~. Information required includes but is not limited to:
- (a) ~~(1)~~ Prior ~~authorizations~~Authorizations approved, denied, or in process;
 - (b) ~~(2)~~ Approved Health ~~Related~~ Services;
 - (c) ~~(3)~~ Program exceptions approved;
 - (d) ~~(4)~~ Current hospitalizations;
 - (e) ~~(5)~~ Information on Members in ~~treatment plans~~Treatment Plans/plans of care who will require ~~continuity~~Continuity of ~~care~~Care consideration;
 - (f) ~~(6)~~ Any other information or records deemed necessary by OHA to facilitate the transition of care.
 - (g) ~~(h)~~ Arrange for the retention, preservation, and availability of all records under this Contract, including, but not limited to those records related to Member ~~grievance~~Grievance and ~~appeal~~Appeal records, litigation, base data, medical loss ratio data, financial reports, claims settlement information, as required by Contract, State and ~~Federal~~federal law.

11. Effect of Termination or Expiration: Other Rights and Obligations.

- a. ~~(13)~~ Expiration of this Contract is deemed to be a termination of this Contract, without regard to whether OHA and Contractor enter into a successor contract, except that:

- (1) ~~(a)~~ OHA need not furnish ~~no~~a Legal Notice or any other type of notice of termination for a termination by expiration;
- (2) ~~(b)~~ If OHA offers Contractor a successor contract to be effective immediately ~~after~~upon expiration of this Contract, then OHA will provide ~~to~~ Contractor ~~a notice with~~ Legal Notice of the proposed terms and conditions of the Contract, as will be submitted by OHA to CMS for approval, and within ~~14 calendar~~fourteen (14) days of receipt of the CMS approved successor contract, Contractor shall provide OHA with ~~a notice~~Legal Notice if Contractor does not intend to enter the successor contract. Such ~~notice~~Legal Notice will not relieve Contractor of any undertakings Contractor has provided to OHA in the procurement for the successor contract;
- (3) ~~(c)~~ If OHA and Contractor enter into a successor contract that is effective immediately after expiration of this Contract, then OHA may waive those duties of Contractor relating to termination of this Contract that OHA deems unnecessary in view of the successor contract; and
- (4) ~~(d)~~ Contractor shall perform the actions described in ~~Paragraph 12~~Sec. 10 of this Ex. D relating to Transition Plan and close-out activities, but only to the extent required by OHA in writing. Contractor shall provide a Transition Plan, to the extent required by OHA in writing, one hundred and twenty (120) days before expiration of this Contract.
- b. ~~(14)~~ After the effective date of termination (or expiration as provided for in Para. a. of this Sec. 11 of Ex. D) of the Contract, Contractor shall:
- (1) ~~(a)~~ Maintain compliance with all financial requirements set forth in this Contract, including but not limited to restricted reserves and insurance coverage, for unless a longer period of time is expressly required elsewhere in this Contract, eighteen (18) months following the date of termination, or until OHA provides the Contractor written release agreeing that all continuing obligations of this Contract have been fulfilled, whichever is earlier.
- (2) ~~(b)~~ Maintain claims processing functions as necessary for a minimum of eighteen (18) months after the date of termination (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims and appeals.
- (3) ~~(c)~~ Assist OHA with Grievances and Appeals for ~~dates~~Dates of ~~service~~Service prior to the termination date.
- (4) ~~(d)~~ ~~Submit~~Provide as required in Exhibit L to this Contract the financial reporting deemed necessary by OHA, including but not limited to:
- (a) ~~(1)~~ Quarterly and Audited Financial Statements up to the date specified by OHA;
- (b) ~~(2)~~ Details related to any existing third-party liability or personal injury lien cases, except to the extent Contractor transfers the cases to OHA's Third Party Liability (TPL) or Personal Injury Lien (~~PHL~~) units, as applicable.
- ~~(15)~~ ~~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 120 day notice that Contractor does not intend to Renew~~

and

- c. Unless OHA provides Contractor with Legal or Administrative Notice that Contractor shall do otherwise, Contractor shall, during the Transition Period or during the one hundred and twenty (120) day period preceding this Contract, the following provisions shall apply's Expiration Date, in order to ensure Members receive continuity of the Work by Contractor. Contractor shall ensure services, do all of the following:
- (1) ~~(a) Continuation of~~Continue to provide services to Members for the period in which a CCO Payment has been made, including inpatient admissions up until discharge;
 - (2) ~~(b) Orderly Plan and carry out an orderly~~ and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;
 - (3) ~~(c) Timely~~Continue to provide timely submission of information, reports and records, including ~~encounter data~~Encounter Data, required to be provided to OHA during the term of this Contract; and
 - (4) ~~(d) Timely~~Continue to make timely payment of Valid Claims for services to Members for dates of service during the term of this Contract; ~~and.~~
- d. ~~(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~~Fee-for-serviceService basis even 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.
- e. ~~(16)~~ Upon termination, OHA ~~shall will~~ conduct an accounting of both CCO Payments paid or payable and Members enrolled during the month in which termination is effective ~~and shall be accomplished.~~ Payment will then be calculated and Paid to Contractor as follows:
- (1) ~~(a) Mid-Month Termination~~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.
 - (2) ~~(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.
 - (3) ~~(c)~~ Notification of Outstanding OHA Claims: Contractor shall promptly ~~notify~~provide OHA with Administrative Notice of any outstanding claims for which OHA may owe, or be liable for, a ~~fee~~Fee-for-serviceService payment(s), which are known to Contractor at the time of termination or when such new claims incurred prior to termination are received. In connection with such Administrative Notice, Contractor shall supply OHA with all information necessary for reimbursement of such claims.
 - (4) ~~(d)~~ Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to ~~encounter data~~Encounter Data for services received by Members during the period of this Contract. Contractor is responsible for ~~submitting~~Submitting financial and other reports required during the period of this Contract to OHA's Contract Administrator via Administrative Notice.
 - (5) ~~(e)~~ Withholding: ~~If~~Regardless of the reason for termination of this Contract ~~is terminating for any reason and, in the event~~ OHA has not approved a Contractor's Transition Plan by

sixty (60) days ~~before~~prior to the termination date, ~~then~~ OHA ~~may~~will have the right to withhold 20% of the Contractor's CCO Payment(s) for the last month ~~of the contract~~this Contract remains in effect and such amount shall be held by OHA, until OHA has given written approval to the Contractor's Transition Plan.

- f. ~~(17)~~—After Contractor has satisfied all of its obligations under this Contract, including post-termination obligations and any obligations under any Transition Plan, Contractor shall submit to OHA a written request for release of restricted reserves, stating (under penalty of false claims liability) that all Contractor's obligations under this Contract and any Transition Plan have been satisfied. OHA will thereupon provide a written release of reserves, when OHA is satisfied that Contractor has satisfied all of its obligations under this Contract and any Transition Plan.

12. ~~10.~~ Limitation of Liabilities

- a. ~~NEITHER SUBJECT TO PARA. b. BELOW OF THIS SEC. 12, EX. D, NEITHER PARTY SHALL BE LIABLE FOR LOST PROFITS, DAMAGES RELATED TO DIMINUTION IN VALUE, INCIDENTAL, SPECIAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES ARISING OUT OF OR RELATED TO THIS CONTRACT.—UNDER THIS CONTRACT.~~
- b. NOTWITHSTANDING THE LIMITATIONS SET FORTH IN PARA. a ABOVE OF THIS SEC. 12, EX. D CONTRACTOR SHALL BE LIABLE FOR : (i) FOR CIVIL PENALTIES UNDER EX. B,PART 9 OF THE CONTRACT; (ii) FOR LIQUIDATED DAMAGES UNDER EX. B-PART 9 OF THE CONTRACT; (iii) UNDER THE OREGON FALSE CLAIMS ACT; (iv) FOR INDEMNIFIABLE EVENTS UNDER EX. D, SEC. 8 ABOVE; (v) CLAIMS ARISING OUT OF OR RELATED TO UNAUTHORIZED DISCLOSURE OF CONFIDENTIAL RECORDS OR INFORMATION OF MEMBERS (OR BOTH OF THEM), INCLUDING WITHOUT LIMITATION RECORDS OR INFORMATION PROTECTED BY HIPAA OR 42 CFR PART 2, (vi) OHA'S EXPENSES RELATED TO TERMINATION; OR (VII) DAMAGES SPECIFICALLY AUTHORIZED UNDER ANOTHER PROVISION OF 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.~~

13. ~~11.~~ Insurance

Contractor shall, from the Contract Effective Date through the date of termination or Expiration Date of this Contract, maintain insurance as set forth in Exhibit F, attached hereto.

14. Transparency: Public Posting of Contractor Reports

- a. In accordance with the requirements set forth in Section 54(3)(d) of Oregon Senate Bill 1041, all reports required to be submitted by Contractor to OHA under this Contract will be made readily available to the public on OHA's website. However, Contractor shall, after submission of a report, create a copy and redact all information protected from disclosure under State or federal law, including Trade Secrets as such term is defined under ORS 192.345.
- b. After providing OHA with a report in accordance with the applicable provision of this Contract, Contractor shall have twenty (20) Business Days to redact all Trade Secrets and other information protected from disclosure under State or federal law. Once such report has been redacted, Contractor shall resubmit such report to OHA Via Administrative Notice to the same email address used to submit the initial, unredacted report to OHA. Contractor shall provide

OHA, together with its redacted report, with a Trade Secret redaction log, which shall be made using the Trade Secrets Redaction Log form posted on CCO Contract Forms Website. Contractor shall use the Redaction Log to document its support for each and every redaction made to the report that is subject to submission. If Contractor makes a Trade Secret claim which OHA determines does not meet the definition of a Trade Secret under ORS 192.345, OHA will provide Contractor's Contract Administrator with Administrative Notice of such determination identifying the redactions that do not constitute a Trade Secret. Within ten (10) days after receipt of such Administrative Notice, Contractor shall either resubmit a new report with only those redactions, if any, identified by OHA in its Administrative Notice or contest such determination by following the process set forth in Sec. 5 of this Exhibit D.

- c. Under ORS 192.345, a Trade Secret protected from disclosure may include: (i) any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data or compilation of information, (ii) which is not patented, (iii) which is known only to certain individuals within an organization, (iv) which is used in a business, (v) has actual or potential commercial value, and (vi) which gives its user an opportunity to obtain a business advantage over competitors who do know such information or do not use it. Accordingly, a Trade Secret includes, without limitation:
- (1) Compensation paid to Providers,
 - (2) Other fee arrangements and methodologies for determining fee arrangements, and
 - (3) Exhibit L, financial report

15. ~~12.~~ Access to Records and Facilities

Contractor shall maintain, and require its Subcontractors and Participating Providers to maintain, all financial records relating to this Contract in accordance with ~~generally accepted accounting principles~~ best practices 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 any other form, that are pertinent to this Contract, are collectively referred to as "Records." Contractor acknowledges and agrees that OHA, CMS, the Oregon Secretary of State's ~~Office~~, DHHS, the Office of the Inspector General, 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 of Contractor and its Subcontractors and~~ Participating Provider, and Subcontractor Records for the purpose of performing examinations and audits and make excerpts and transcripts, evaluating compliance with this Contract, and to evaluate the quality, appropriateness and timeliness of services. Contractor further acknowledges and agrees that the foregoing entities may, at any time, inspect the premises, physical facilities, computer systems, and any other equipment and facilities where Medicaid-related activities or ~~work~~ Work is conducted or equipment is used (or both conducted and used). The right to audit under this section exists for 10 years from, as applicable, the final ~~Expiration Date or the~~ date of the contract period termination, or from the date of completion of any audit, whichever is later. Contractor shall retain and keep accessible all Records for the longer of ten years or:

- a. The retention period specified in this Contract for certain kinds of records;
- b. The period as may be required by applicable law, including the records retention schedules set forth in OAR Chapters 410 and 166; or

- c. Until the conclusion of any audit, controversy or litigation arising out of or related to this Contract.

Contractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilitate such a review or audit. This right also includes timely and reasonable access to Contractor's personnel and Subcontractors for the purpose of interview and discussion related to such documents. The rights of access in this section are not limited to the required retention period, but shall last as long as the records are retained.

16. ~~13.~~ 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.

17. ~~14.~~ 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, earthquake, tsunami, flood, or other similar natural disaster 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~~Legal Notice to Contractor after ~~reasonably~~ determining in OHA's reasonable discretion, 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~~Para. a., Sec. 17 above, of this Ex. D. 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 thirty (30) days.
- c. If any of the circumstances listed in ~~Section 15~~P. a., Sec. 17 above, of this Ex. D. 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~~reasonably 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.

18. ~~15.~~ 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.

19. ~~16.~~ 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~~Section 14. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in the Contract.
- b. The provisions of this Contract shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

20. ~~17.~~ 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~~all of the other provisions OHA ~~may require~~requires under this Contract, including, without limitation, information required to be reported under Ex. B, Part 4 of this Contract, and any other information OHA may requests from time to time, Contractor shall include in any permitted ~~subcontract~~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~~15, ~~14~~16, ~~17, 18~~19, 20, 25, and ~~22~~31-33 of this Exhibit D. OHA's consent to any ~~subcontract~~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.~~

21. ~~18.~~ 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.

22. ~~19.~~ Amendments

- a. OHA may amend this Contract to the extent provided herein, or in RFA OHA 4690-19-0, and to the extent permitted by ~~applicable statutes and administrative rules~~Applicable Law. No amendment, modification, or change of terms of this Contract shall ~~bind~~be binding on either ~~party~~Party unless made in writing and signed by both ~~parties~~Parties and when required approved by the Oregon Department of Justice. ~~Such~~Any 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, from time to time, require~~ Contractor ~~with~~to enter into an amendment to this Contract under any of the following circumstances:

- (1) ~~If OHA is required to amend this Contract due~~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/or~~ if failure to amend this Contract to ~~execute~~effectuate 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) To amend CCO Payment rates once within the first eight months of Contract Year one (2020) as may be necessary to adjust Contractor's Global Budget, which will be retroactive to the beginning of the Coverage Effective Date in alignment with Contractor's Membership or the health status of Contractor's Members;
- (4) ~~(3) If this Contract is amended to~~To reduce or expand the Service Area, ~~or~~ reduce or expand the Enrollment limit, or both, and ~~a~~any CCO Payment Rate change ~~is as may be necessary to align with the expansion or reduction thereof and which will be made under~~in accordance with Exhibit ~~BC, Part 4, Section 11.~~Sec. 3 of this Contract;
- (5) As required by CMS; and
- (6) ~~(4)~~ To the extent OHA deems such changes are ~~required~~necessary to obtain CMS approval of this Contract or the CCO Payment Rates.

Except as otherwise permitted by law, OHA will send to Contractor ~~the necessary~~any Contract amendments no later than sixty (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~~Amendment to go into effect on its proposed effective date, is a default of Contractor under ~~Exhibit D, Paragraph Sec. 10, Para. a., Sub. Para. (6) of this Ex. D.~~

~~c. Per capita rates are actuarially certified annually. Rates will be amended annually along with required language changes, as allowed for in ORS 414.652 (1) and Exhibit C, Section 10.~~

~~c. d.~~ Any changes in the CCO Payment Rates under ORS 414.735 shall take effect ~~on no sooner than sixty (60) days following final legislative action approving the date approved~~reductions by the Legislative Assembly or the Legislative Emergency Board approving such changes. 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.

23. ~~20.~~ 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.

24. ~~21.~~ Severability

If any term or provision of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Contract did not contain the particular term or provision held to be invalid.

25. ~~22.~~ Survival

~~a. Standard Terms and Conditions~~

~~Sections 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 22 and 23~~

All rights and obligations cease upon termination or expiration of this ~~Exhibit D shall survive~~ Contract expiration or termination, as well as those, except for the rights and obligations, and declarations which expressly or by their nature survive termination of this Contract, including without limitation the following Sections or provisions ~~offset for the below in this Contract that by their context are meant to survive.~~ S. 24. Without limiting the forgoing or anything else in this Contract, in no event shall 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.

a. Exhibit A, Definitions

b. General Provisions: Sections V and VI

c. Ex. B, Part 10, Sec. 3

d. Ex. D: Standard Terms and Conditions

e. Sections 1, 4 through 24, Sec. 26.a. 26-29 Ex. E: Required Federal Terms and Conditions:

Section 6, HIPAA Compliance (but excluding paragraph d) shall survive termination for as long as Contractor holds, stores, or otherwise preserves Individually Identifiable Health Information of Members or for a longer period if required under Section 12 of this Exhibit D.

f. ~~b.~~ Special Terms and Conditions

In addition to any other provisions of this Contract that by their context are meant to survive Contract expiration or termination, the following special terms and conditions survive Contract expiration or termination, for a period of ~~2~~(2) years unless a longer period is set forth in this Contract:

(1) Claims Data

- (a)** The submission of all ~~encounter data~~Encounter Data for services rendered to Contractor’s Members during the contract period;
- (b)** Certification that Contractor attests that the submitted encounter claims are complete, truthful and accurate to the best knowledge and belief of the Contractor’s authorized representative, subject to False Claims Act liability;
- (c)** Adjustments to encounter claims in the event Contractor receives payment from a Member’s Third Party Liability or Third Party ~~Recovery~~recovery; and
- (d)** Adjustments to encounter claims in the event Contractor recovers any ~~overpayment~~Provider Overpayment from a Provider.

(2) Financial Reporting

- (a)** Quarterly financial statements as defined in Exhibit L;
- (b)** Audited annual financial statements as defined in Exhibit L;
- (c)** Submission of details related to ongoing Third Party Liability and Third Party ~~Recovery~~recovery activities by Contractor or its Subcontractors;

- (d) Submission of any and all financial information related to the calculation of Contractor's MMLR; and
 - (e) Data related to the calculation of quality and performance metrics.
- (3) Operations
- (a) Point of contact for operations while transitioning;
 - (b) Claims processing;
 - (c) Provider and ~~member grievances~~Member Grievances and ~~appeals~~Appeals; and
 - (d) Implementation of and any necessary modifications to the Transition Plan.
- (4) Corporate Governance
- (a) Oversight by governing board and ~~community advisory council~~Community Advisory Council;
 - (b) Not initiating voluntary bankruptcy, liquidation, or dissolution;
 - (c) Maintenance of all licenses, certifications, and registrations necessary to do the business of a CCO in Oregon; and
 - (d) Responding to subpoenas, investigations, and governmental inquiries.
- (5) Financial Obligations
- The following requirements survive Contract expiration or termination indefinitely:
- (a) Reconciliation of ~~risk corridor payments~~Risk Corridor Payments;
 - (b) Reconciliation and right of setoffs;
 - (c) Recoupment of MMLR Rebates;
 - (d) Reconciliation of prescription drug rebates;
 - (e) Recoupment of capitation paid for ~~members~~Members deemed ineligible or who were enrolled into an incorrect benefit category; and
 - (f) Recoupment (by means of setoff or otherwise) of any identified ~~overpayment~~Overpayment.
- (6) Sanctions and Liquidated Damages
- (a) Contract expiration or termination does not limit OHA's ability to impose a ~~sanction~~Sanction or ~~apply~~ Liquidated Damages for the failures or acts (or both) as set out in Exhibit B, Part 9.
 - (b) The decision to impose a ~~sanction~~Sanction or ~~apply~~ Liquidated Damages does not prevent OHA from imposing additional ~~sanctions~~Sanctions at a later date.

Sanctions imposed on Contractor after Contract expiration or termination will be reported to CMS according to the requirements set out in Exhibit B—, Part ~~89~~.

~~23.~~ Notices

26. Legal Notice; Administrative Notice. Except as expressly provided otherwise in this Contract, communications required under this Contract shall be made in accordance with the terms set forth below in this Sec. 26. In the event a particular provision in this Contract is silent with respect to the means or method, or both means and method, of communication, the communication shall be made to OHA's Contract Administrator by means of Administrative Notice (as set forth below in Paragraph b. of this Sec. 26.).

~~a. Except as otherwise expressly provided in this Contract, any notices 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:~~ “Legal Notice” (also, “Legally Notify” and “Legal Notification”) means a written communication required to be made under this Contract and which shall be deemed duly given and effective only when delivered as follows: (a) one (1) Business Day after being delivered by hand to the addressee (b) five (5) Business Days after being placed with the US Postal Service and sent via certified mail, return receipt requested with postage paid; or (c) one (1) Business Day after being placed with a reputable over-night commercial carrier, fees pre-paid, and addressed as follows:

~~(1) If given by personal delivery, when actually delivered to the addressee.~~ to OHA:
Oregon Health Authority

~~(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/OHA Shared Services
635 Capitol~~

Health Systems Division (HSD)
500 Summer Street NE Room 350, E35
Salem, Oregon 97301

~~Telephone: 503-945-5818
Facsimile: 503-378-4324~~

ATTN: _____

And with copy to (and notwithstanding the above requirements of this Paragraph a., if the copy is sent via U.S. Mail, it need only be sent by first class, not certified mail, in order to be deemed given and effective):

Attorney-in Charge
Health and Human Services Section
General Counsel Division
Oregon Department of Justice
1162 Court Street NE
Salem, Oregon 97301-4096

or to such other Person(s) or address(es) as OHA may identify in writing from time to time in accordance with this Exhibit D. Section. 26.a.

(2) _____ If to Contractor: ~~See Contract Document, Section~~
~~IV.B~~_____

ATTN:

or to such other Person(s) or address(es) as Contractor may identify in writing from time to time in accordance with this Exhibit D. Section. 26.a.

b. “Administrative Notice” (also “Administrative Notification”) means a written communication required to be made under this Contract and which shall be deemed duly given and effective only when delivered via email as follows:

(1) **If to OHA:** To the email address listed in Attachment 1-Exhibit D attached to the last page of the Contract.

(a) or to such other Person(s) or address(es) as OHA may identify in writing from time to time in accordance with this Exhibit D. Section. 26.a.

(b) Contractor shall use its reasonable efforts to include in the subject line of each Administrative Notice email the (i) title of the document attached or purpose of the communication, and (ii) the applicable Section and Exhibit number of the Contract pursuant to which the Administrative Notice is being sent.

(c) In the event this Contract is silent with respect to the means or method, or both means and method, of communication, and is not listed in Attachment 1-Exhibit D, the communication or deliverable shall be made to OHA’s Contract Administrator by means of Administrative Notice at the following email address:

CCO.MCOCDeliverableReports@state.or.us

(d) In the event this Contract is silent with respect to a due date for any deliverable, Contractor shall request a due date from OHA via Administrative Notice sent to the email address in Sub.Para. (1)(c) of this Para. b, Sec. 26, Ex. D.

(2) **If to Contractor:**

or to such other Person(s) or address(es) as Contractor may identify in writing from time to time in accordance with this Exhibit D. Section. 26. a.

27. 24. Construction

This Contract is the product of extensive negotiations between OHA and Contractor. The provisions of this Contract are to be interpreted and their legal effects determined as a whole. 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.

28. 25. Headings

The headings and captions to sections of this Contract have been inserted for identification and reference purposes only and shall not be used to construe the meaning or to interpret this Contract.

29. ~~26.~~ Merger Clause

This Contract constitutes the entire agreement between the parties on the subject matter hereof. There are no understandings, agreements, or representations, oral or written, not specified herein, regarding this Contract.

30. ~~27.~~ Counterparts

This Contract and any subsequent ~~amendments~~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~~Amendments so executed shall constitute an original.

31. ~~28.~~ Equal Access

Contractor shall provide equal access to Covered Services for both male and female Members under 18 years of age, including access to appropriate facilities, services and treatment, to achieve the policy in ORS 417.270.

32. ~~29.~~ Media Disclosure

Contractor shall not provide information to the media regarding a recipient of services under this Contract without first consulting with and receiving approval from the OHA ~~case manager that referred the child or Family~~. Contractor shall make immediate contact with the OHA office when media contact occurs. The OHA office will assist the Contractor with an appropriate follow-up response for the media.

33. ~~30.~~ Mandatory Reporting of Abuse

- 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 407-045-0000 through 407-045-0370 (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).

[\[Remainder of page intentionally left blank\]](#)

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) Section 1557 of the Patient Protection and Affordable Care Act (ACA), (e) Executive Order 11246, as amended, (f) the Health Insurance Portability and Accountability Act of 1996, as amended, (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws, (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (m) 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 USC. 14402.

2. Equal Employment Opportunity

If this Contract, including ~~amendments~~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~~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 USC. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC. 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 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 in writing to: (a) OHA via Administrative Notice, (b) United States Department of Health and Human Services, and (c) the appropriate Regional Office of the federal 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 USC 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~~the certification made under this S. 5 of this Exhibit E 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~~The certification made under this S. 5 of this Exhibit E 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 on 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/cfl/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, [via Administrative Notice](#) 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~~[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~~Subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.
- b. If Contractor expends \$750,000 or more in federal funds (from all sources) in a federal fiscal year, 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~~provided, via Administrative Notice to OHA, within thirty (30) days of completion. If Contractor expends less than \$750,000 in a federal fiscal year, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, "Records Maintenance, Access."

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~~Controlled by a ~~sanctioned~~Sanctioned individual
- b. The Provider has a contractual relationship that provides for the administration, management or provision of ~~medical services~~Medical Services, or the establishment of policies, or the provision of operational support for the administration, management or provision of ~~medical services~~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~~Utilization Review, medical social work, or administrative services, with one of the following:
 - (1) Any individual or entity excluded from participation in ~~Federal~~federal health care programs.
 - (2) Any entity that would provide those services through an excluded individual or entity.
- d. The Contract prohibits the Contractor from knowingly having a person with ownership of 5% or more 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.
- e. 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:
 - (1) Must notify DHHS of Contractor's noncompliance;
 - (2) May continue an existing agreement with the Contractor unless DHHS directs otherwise; and
 - (3) ~~May~~Shall have the right not ~~renew~~to Renew or extend ~~the existing contract~~this Contract with the Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for ~~renewing~~Renewing or extending ~~the~~this Contract, consistent with 42 CFR 438.610.

10. 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.).

11. Additional Medicaid and CHIP

Contractor shall comply with all applicable federal and State laws and regulations pertaining to the provision of OHP ~~Servicees~~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 ~~Servicees~~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 ~~Servicees~~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.

12. 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.

13. Clinical Laboratory ~~Improvements~~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.

14. **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 ninety (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~~Advance Directive per 42 CFR §438.3(j); 42 CFR §422.128; or 42 CFR §489.102(a)(3).

15. **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.

16. **Risk HMO**

If Contractor is a Risk HMO and is ~~sanctioned~~Sanctioned by CMS under 42 CFR 438.730, ~~payments~~Payments provided for under this Contract will be denied for Members who enroll after the imposition of the ~~sanction~~Sanction, as set forth under 42 CFR 438.726.

17. **Conflict of Interest Safeguards**

- a. Contractor shall not offer, promise, or engage in discussions regarding future employment or business opportunity with any DHS or OHA employee (or their relative or ~~member~~Member of their household), and no DHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such DHS or OHA employee participated personally and substantially in the procurement or administration of this Contract as a DHS or OHA employee.
- b. Contractor shall not offer, give, or promise to offer or give to any DHS or OHA employee (or any relative or ~~member~~Member of their household), and such employees shall not accept, demand, solicit, or receive 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 and OAR 199-005-0001 to 199-005-0035.

- c. Prior to the award of any replacement contract, Contractor shall not solicit or obtain, from any DHS or OHA employee, and no DHS or OHA employee may disclose, any proprietary or source selection information regarding such procurement, except as expressly authorized by the Director of OHA or DHS.
- d. 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.
- e. 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.
- f. Contractor shall develop and maintain (and update as may be needed from time to time) a Conflict of Interest Safeguards Handbook wherein Contractor shall set forth appropriate, written policies and procedures to avoid actual or potential conflict of interest involving Members, DHS, or OHA employees, and ~~sub-contractors~~Subcontractors. These policies and procedures shall include, at a minimum, safeguards:
 - (1) against the Contractor’s disclosure of ~~applications~~Applications, bids, proposal information, or source selection information; and
 - (2) requiring the Contractor to:
 - (a) promptly report, but in no event seven (7) Business Days after impermissible contact, any contact with ~~an~~ Contractor, bidder, or offeror in writing via Administrative Notice to OHA’s Contract Administrator; and
 - (b) reject the ~~possibility~~any offer or proposed offer 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 Contractor~~a contractor, bidder, or offeror in a procurement involving federal funds regarding possible employment for the Contractor.
- h. Contractor shall provide OHA its Conflict of Interest Safeguards Handbook within five (5) Business Days of OHA’s request or at the request of (i) Oregon Secretary of State, (ii) the federal government’s Office of Inspector General, (iii) the federal Government Accountability Office, (iv) CMS, and (v) any other authorized state or federal reviewers, for the purposes of audits or inspections. The foregoing agencies shall have the right to review and approve or disapprove such Handbook for compliance with this S. 17 of this Exhibit E which shall be provided to Contractor within thirty (30) days of receipt. In the event OHA disapproves of the Conflict of Interest Safeguards Handbook, Contractor shall, in order to remedy the deficiencies in such Handbook, follow the process set forth in Sec. 5, Ex. D of this Contract.
- g. The provisions of this ~~section on~~Section 17 of Exhibit E, Conflict of Interest Safeguards, 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~~Member of household~~”;~~”.
- (3) “Contractor” for purposes of this section includes all Contractor’s ~~affiliates~~Affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common ~~control~~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).

(6)

18. **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.

19. **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.

20. **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~~Hospitals.

21. **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.

22. **Mental Health Parity**

Contractor shall adhere to CMS guidelines regarding Mental Health Parity detailed below:

- a. If Contractor does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to ~~enrollees~~Members, it may not

- impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits;
- b. If Contractor includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to ~~enrollees~~Members, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits;
 - c. If Contractor includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to ~~enrollees~~Members, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR §438.905(e)(ii);
 - d. Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to ~~enrollees~~Members (whether or not the benefits are furnished by Contractor).
 - e. If a ~~member~~Member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the ~~member~~Member in every classification in which medical/surgical benefits are provided;
 - f. Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification;
 - g. Contractor may not apply more stringent utilization or Prior Authorization standards to mental health or substance use disorder, then standards that are applied to medical/surgical benefits.
 - h. Contractor may not impose NQTLs for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification;
 - i. Contractor shall provide all necessary documentation and reporting required by OHA to establish and demonstrate compliance with 42 CFR part 438, subpart K regarding parity in mental health and substance use disorder benefits.
 - j. Contractor shall use processes, strategies, evidentiary standards or other factors in determining access to out of network ~~providers~~Providers for mental health or substance use disorder benefits that are comparable to and applied no more stringently than, the processes, strategies, evidentiary

standards or other factors in determining access to out of network ~~providers~~Providers for medical/surgical benefits in the same classification.

[Remainder of page intentionally left blank]

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~~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~~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. **Administrative 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 sixty (60) days prior written notice from Contractor or its insurer(s) via Administrative Notice 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~~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~~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~~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, via Administrative Notice to OHA within five (5) Business Days after execution of this Contract, 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.

[Remainder of page intentionally left blank]

Exhibit G—

Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy

1. Delivery System Network (~~DSN~~)ReportsProvider Monitoring and Reporting Overview

~~Contractor shall submit to OHA a DSN Provider Report as specified in this Section no later than 30 days following the end of each quarter. Subsequently, Contractor shall update these reports any time there has been a change in Contractor's provider network including terminating a provider or upon expiration of a provider agreement, and at OHA request.~~

~~Contractor shall maintain and monitor a Participating Provider Panel that is supported with written agreements. Contractor shall ensure to encompass the scope of network adequacy standards established in accordance with paragraphs (b)(1) and (2) of 42 CFR 438.206 must provide for member access in all geographic areas covered by the managed care program or, if applicable, the contract between the State and CCO.~~

2.

a. Contractor must employ or subcontract with, as required under 42 CFR §438.206, Ex. B, Part 4 and any other applicable provisions of this Contract, enough Providers to meet the needs of its Members in all categories of service, and types of service Providers, such that Members have timely and appropriate access to services. Contractor shall develop its Provider Network that is consistent with 42 CFR §438.68, 42 CFR §457.1230, and OAR 410-141-3220 and shall incorporate the priorities from its Community Health Assessment, its Community Health Improvement Plan, and Transformation and Quality Strategy such that Contractor's Provider Network is capable of providing integrated and coordinated physical, Oral Health, mental health, and Substance Use Disorders treatment services and supports as required under this Contract.

b. If necessary to ensure access to an adequate ~~provider network~~Provider Network, Contractor may be required to contract with ~~providers~~Providers located outside of the defined ~~service area~~Service Area.

~~Contractor shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, maintain a Provider Panel of sufficient capacity and expertise to provide adequate, timely and Medically Appropriate access to members and ensure access to a provider network that meets time and distance standards in OAR 410-141-3220 and the time to appointments timeframes in OAR 410-141-3220.~~ shall Monitor, document, report and evaluate its Provider Network as set forth in this Ex. G.

~~Contractor agrees to promptly and fully remedy any provider network deficiencies identified through the course of self-assessment, OHA monitoring, EQRO review, or any other source as defined by OHA.~~

~~When developing its provider network, Contractor agrees to contract with a sufficient number of providers to ensure that at minimum 90% of its enrollees do not exceed routine travel time or distance standards established in OAR 410-141-3220 when using a means of transportation ordinarily used by enrollees.~~

~~Contractor agrees to develop a system and methodology for monitoring and evaluating member access including, but not limited to:~~

~~a. Travel time and distance to providers;~~

~~b. Wait time to appointment for primary care, specialty care, oral health, and behavioral health services;~~

- ~~e. — Provider to enrollee ratios;~~
- ~~d. — Percentage of contracted providers accepting new OHP members;~~
- ~~e. — Hours of operation;~~
- ~~f. — Call center performance and accessibility;~~
- ~~g. — Availability of language services and accommodations for physical accessibility; and~~
- ~~h. — Any other measure defined in OAR 410-141-3220.~~

~~2. — DSN Provider Report~~

- ~~a. — Pursuant to 42 CFR 438.68 “Network adequacy standards” and 457.1230 Access standards,” Contractor shall report to OHA annually, in a form provided by OHA, (a) how Contractor monitors and ensures that all Covered Services are available and accessible to Members, pursuant to 42 CFR 438.206 and 457.1230 CHIP, and (b) that the Contractor maintains adequate Provider capacity and meets access standards defined in contract or in OAR 410-141-3220. When developing its provider network, Contractor agrees to contract with a sufficient number of providers to ensure that at minimum 90% of its enrollees do not exceed routine travel time or distance standards established in OAR 410-141-3220 when using a means of transportation ordinarily used by enrollees.~~
- ~~d. b.~~ Contractor agrees to develop’s obligations under Para. c, above of this Ex. G, shall include the development of a system and methodology for monitoringMonitoring and evaluating memberMember access including, but not limited to, the availability of network providersProviders within time and distance standards, adherence to standards for wait time to appointment for primary care, specialty care, and behavioral healthBehavioral Health services, and sufficiency of language services and physical accessibility.
- ~~e.~~ Contractor agrees to shall promptly and fully remedy any provider networkProvider Network deficiencies identified through the course of self-assessment, or as a result of OHA monitoringMonitoring, or EQRO review.
- ~~f.~~ e. The accuracy of data submitted in the DSN Provider Report will be periodically validated against available sources. If data for more than 10ten percent (10%) of providersProviders is incorrect for individual data elements, OHA mayshall have the right to require Contractor to implement a Corrective Action Plan, or issue penalties or sanctions associated with failure to maintain an adequate provider networkcorrect its data. If data errors are persistent, OHA shall have the right to require Contractor to, in addition to correcting its data, provide OHA monthly DSN Provider Reports, and OHA shall have the right to pursue any and all of its rights and remedies under this Contract.
- ~~g.~~ d. If any activities have been subcontracted or delegated, Contractor must also describe its oversight and monitoringMonitoring procedures to ensure compliance with the requirements of this Contract.

3. Delivery System Network Provider Monitoring and Reporting Requirements.

- ~~a. e.~~ Contractor shall include in the DSN Provider Report a description of: provide OHA with a quarterly DSN Provider Report no later than thirty (30) days following the end of each calendar quarter. In addition, Contractor shall update such Reports any time there has been a change in Contractor’s Provider Network including terminating a Provider or upon expiration of a Provider

agreement, and at OHA request. Contractor shall utilize the DSN Provider Capacity and Narrative Report Template located on CCO Contract Forms Website to create such quarterly Report, which, once completed shall be provided to OHA via Administrative Notice.

- (1) All of Contractor's Providers must be included in the DSN Provider Report. Notwithstanding the foregoing, in order to include a Provider and contracted facilities in its quarterly DSN Provider, such Provider whether employed Subcontracted, must have agreed to provide services to both Medicaid and Fully Dual Eligible Members.
- (2) Providers listed in DSN Provider Report shall be categorized by Provider Taxonomy Code.
- (3) For patient centered primary care homes, information should include the certification Tier and the number of Members assigned to the Network Provider participating as a PCPCH.

b. Contractor shall Monitor its Provider Network with respect to all of the following criteria:

- (1) Travel time and distance to Providers;
- (2) Wait time to appointment for primary care, specialty care, Oral Health, and Behavioral Health services;
- (3) Provider to Member ratios;
- (4) Percentage of contracted Providers accepting new OHP members;
- (5) Hours of operation;
- (6) Call center performance and accessibility;
- (7) Availability of oral and sign language interpreter and written translation services;
- (8) Availability to make accommodations for physical accessibility; and
- (9) Any other measure or criteria, or both, set forth in OAR 410-141-3220 or otherwise enables OHA to determine compliance under 42 CFR §438.206, 42 CFR §438.68 and 42 CFR §457.1230.

c. Contractor shall also include in the DSN Provider Report descriptions of all of the following:

- (1) How ~~contractor~~Contractor identifies and incorporates the needs of linguistically and culturally diverse populations within its ~~community~~Community;
- (2) Processes used to develop, maintain and ~~monitor~~Monitor an appropriate ~~provider-network~~Provider Network that is sufficient to provide adequate access to all services covered under this Contract;
- (3) Processes used to assess timely access to services including the methodology used to collect and analyze ~~enrollee~~Member, ~~provider~~Provider and staff feedback about the ~~provider-network~~Provider Network and performance, and, when specific issues are identified, the protocols for correcting them;
- (4) How Contractor utilizes Grievance and Appeal data to identify ~~member~~Member access issues by geographic area, by ~~provider~~Provider type, by special needs populations, and by ~~subcontractor~~Subcontractor or subcontracted activity;

~~(5)~~ (5) The names of any and all Providers terminated from the Contractor's Provider Network, the reason for each such termination, the number of Members impacted by the Provider termination(s), and any other information required to be included as identified in the DSN Provider Capacity and Narrative Report Template. This reporting requirement is in addition to the reporting requirements set forth in the applicable provisions of Ex. B, Part 3 and Ex. B, Part 9 and any other reporting requirements under this Contract regarding terminated Providers; and

~~(6)~~ (5)-An evaluation of the prior year's report and a description of how previously identified issues have been corrected.

~~d.~~ f.-Contractor shall also include in the DSN Provider Report a description of current barriers to network adequacy, gaps in the Contractor's ~~provider network~~Provider Network, and how it intends to resolve those deficiencies including the following:

- (1) The methodology used to identify barriers and network gaps;
- (2) Immediate short-term interventions to correct network gaps;
- (3) Long-term interventions to fill network gaps and resolve barriers;
- (4) Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers;
- (5) Projection of changes in future capacity needs; and
- (6) Ongoing activities for network development based on identified gaps and future needs projection;

~~(7)~~ Contractor's failure to develop, maintain, monitor and ensure access to an adequate provider network may be grounds for OHA to impose penalties, corrective action, or sanctions as determined by OHA. Notwithstanding any other sanction OHA may choose to impose, if OHA determines that Contractor has failed to maintain a sufficient network of providers, failed to ensure sufficient capacity exists to provide timely access to care for its members, or that circumstances exist that would otherwise jeopardize access to care, OHA may prohibit Contractor from enrolling additional members, allow current members to disenroll or transfer to a different CCO, or require Contractor to arrange for its members to receive services from non-participating providers until such time that the deficiency has been remedied to OHA's satisfaction.

~~e.~~ (8)-Contractor shall include in the DSN Provider Report information and analysis of how it establishes, ensures, ~~monitors~~Monitors and evaluates adequate Provider capacity, including the geographic location of network ~~providers~~Providers and ~~members~~Members, considering distance, travel time, and the means of ~~transportation~~Transportation ordinarily used by ~~members.~~ Contractor shall be accountable for meeting state and federal requirements and responsible for oversight of the following processes, regardless of whether the activities are provided directly, contracted or delegatedMembers.

~~3.~~ 3. Provider Capacity

~~a.~~ a. Contractor shall ensure sufficient provider capacity for all categories of service and types of service providers necessary to ensure timely and appropriate access to services. Contractor's service providers, whether under contract or subcontract with Contractor, must have agreed to

~~provide the described services or items to its Medicaid and Fully Dual Eligible Members to be included in Contractor’s DSN Provider Report. Contractor shall develop its provider network incorporating the priorities from its Community Health Assessment, its Community Health Improvement Plan, and Transformation and Quality Strategy for delivery of integrated and coordinated physical, oral health, mental health, and Substance Use Disorders treatment services and supports.~~

~~b. Contractor shall complete the DSN Provider report and include all the required data elements in the report for both individual Providers and contracted Facilities.~~

~~e. Providers listed in DSN Provider Report shall be categorized by Provider Taxonomy Code. All providers under contract with Contractor or its Subcontractors to provide services to its members must be listed in the DSN Provider Report.~~

~~For patient centered primary care homes, information should include the certification Tier and the number of Members assigned to the Network Provider participating as a PCPCH.~~

~~d. Contractor shall identify any providers who have been terminated from the Contractor’s provider network, the reason for termination, the number of members impacted by the termination, and any other information listed on the report.~~

~~e. For any Provider that has been terminated for cause, whether that Provider is contracted directly or through Contractor’s Subcontractor or delegated entity to provide services, Contractor must notify OHA in writing within 30 days that the Provider is no longer available to its members. Contractor must provide the reason for the termination and indicate how many members are affected by the termination, and whether the termination was the result of issues related to quality, fraud, abuse, or non-compliance with state or federal law.~~

~~f. The accuracy of data submitted in the DSN Provider Report will be periodically validated against available sources. If data for more than 10 percent of providers is incorrect for individual data elements, or if providers are listed who do not have written agreements to provide services to Contractor’s members, OHA may require Contractor to implement a Corrective Action Plan, or issue penalties or sanctions associated with failure to maintain an adequate provider network.~~

3. 4. Cooperative Agreements with Publicly Funded Programs Report:

a. To implement and formalize coordination and ensure relationships exist between Contractor and publicly funded health care and service programs, Contractor shall complete the following reproduce and complete the table below and submit~~provide~~ it to ~~the OHA Contract Administration Unit~~OHA via Administrative Notice, by July 1st of every year. In the event OHA requires additional information regarding Contractor’s relationship with publicly funded programs, OHA shall have the right to request, and Contractor shall 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 <u>Subcontract</u> , etc.)?
	Local Mental Health Authority			
	Community Mental Health Programs			
	Type B AAA			
	State APD district offices			
	Local public health authority			

4. ~~5.~~ Cooperative Agreements with Community Social and Support Service and Long Term Care Report:

a. 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 report to OHA Contract Administration Unit via Administrative Notice, by July 1st of every year, ~~and, . . . In the event OHA requires additional information regarding Contractor’s relationship with Community social and support service organizations, or long term care organizations (or all, or any combination, of them), OHA shall have the right to request, and Contractor shall provide, additional information upon OHA request.~~

- (1) Referral and cooperative arrangements with culturally diverse social and support services organizations, as required to be established by under the applicable provisions of Exhibit B, Part 4, Subsection (5)(e) of this Contract.
- (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) of this Contract.~~
- (3) Cooperative arrangements and agreements with DHS Child Welfare offices to assure timely ~~assessments~~Assessments for Member children placed under Child Welfare custody, as required by Exhibit B, Part 2, ~~Subsection (4)(m)(3)(g) of this Contract.~~

5. ~~6.~~ Hospital Network Adequacy

~~**a.**— This Hospital Adequacy Report is an annual report that details Hospital admissions and paid amounts 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. Contractor shall submit to the OHA Contract Administration Unit (CAU) by March 31 following the end of the calendar year reporting period. The Hospital Adequacy Report template is 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.~~

- ~~a.~~ ~~b.~~ Contractor shall develop and maintain an adequate Hospital network for a full range of services to sufficiently meet the needs of the Contractor's Members.

~~(1) — Definitions:—~~

- ~~b.~~ For each Contract Year, Contractor must Monitor, document, and provide a Hospital Adequacy Report to OHA using the Hospital Adequacy Report Template located on CCO Contract Forms Website. The Hospital Adequacy Report shall be provided to OHA via Administrative Notice by March 31 of each Contract Year which reflects the Monitoring and documentation undertaken in the previous Contract Year. OHA will advise Contractor in writing by no later than November 1 of the fifth Contract Year the due date for the 2025 Hospital Adequacy Report.

- ~~c.~~ For this Section 5 of Ex. G, the following definitions apply:—

~~(1)~~ Contracted Hospital - in this Exhibit G means a Hospital that is a Subcontractor.

~~(2)~~ Non-Contracted Hospital – in this Exhibit G means a Hospital that is not a Subcontractor.

- ~~d.~~ This Hospital Adequacy Report shall detail Hospital admissions and paid amounts at Contracted Hospitals and Hospital admissions at Non-Contracted Hospitals. The Hospital Adequacy Report must also include Contractor's total outpatient costs at Contracted Hospitals and the Contractor's total outpatient costs at Non-Contracted Hospitals.

- ~~e.~~ OHA will review and analyze non-contracted claims by Contractor annually to determine if all Hospital services are adequately represented.

~~(1)~~ ~~(2)~~ OHA will use following benchmarks ~~will be monitored to evaluate~~ and ~~evaluated to~~ assess the adequacy of ~~a~~ Contractor's Hospital network:

~~(a)~~ ~~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)~~ ~~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.

~~(2)~~ ~~(1)~~ 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~~ Diagnosis Related Groups indicates Contractor's Hospital network is not adequate, OHA ~~shall~~ will determine if the Contractor and Hospital(s) have both made a good faith effort to contract with each other. The determination of good faith under this Sub. Para. (2) Para. 5 of this Ex. G shall ~~consider~~ be based on the following criteria:

~~(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.

(3) ~~(h)~~ If OHA determines that ~~the~~ Contractor has made a good faith effort to contract with the Hospital, OHA ~~shall~~will modify the ~~benchmark~~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~~will have the ~~following remedies (until such time that the~~right to require Contractor ~~achieves the benchmarks or provides documentation to OHA that it has an adequate~~to provide a monthly 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);~~
- ~~(3) — Sanctions described elsewhere in this Contract; and finally,~~
- ~~(4) — Termination or non-renewal of this Contract.~~Adequacy Report and to pursue all of its rights and remedies under this Contract until such breach is remedied.

[Remainder of page intentionally left blank]

Exhibit H – Value Based Payment

Contractor shall demonstrate, as specified below, how it will use Value-~~based-payment~~Based Payment methodologies alone or in combination with delivery system changes to achieve the Triple Aim Goals of better care, controlled costs, and better health for Members.

Contractor shall implement a schedule of Value-~~based-payments~~Based 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.

1. VBP minimum threshold

Starting on the ~~effective-date~~Effective Date of this Contract, Contractor shall make at least twenty percent (20%) of its projected annual payments to its ~~providers~~Providers in contracts that include a ~~value-based-payment~~VBP component as defined by the Health Care Payment Learning and Action Network's ~~(LAN's)~~ "Alternative Payment Model Framework White Paper Refreshed 2017" (<https://hcp-lan.org/apm-refresh-white-paper/>), Pay for Performance LAN category 2C or higher. OHA will assess adherence retrospectively. The denominator in ~~this~~the calculation for determining VBP targets is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Excluded from the calculation for determining VBP targets are the following: (i) Administrative/overhead expenses, (ii) amounts paid to third-parties for network development, claims processing, and utilization management, (iii) amounts paid, including amounts paid to a Provider, for professional or administrative services that do not represent compensation or reimbursement for services (as defined under 42 CFR §438.3(e)) provided to a Member, amounts paid to Providers under 42 CFR §438.6(d), amounts paid as remittance in accordance with 42 CFR §438.6(j), fines and penalties assessed by regulatory authorities, profit/margin, and other non-service-related expenditures are excluded from the calculation.

In addition to the ~~LAN-Framework~~LAN Framework, Contractor shall use the ~~Value-based-payment~~VBP Roadmap for Coordinated Care Organizations and the OHA ~~Value-based-Payment Roadmap Categorization Guidance~~VBP Technical Guide for Coordinated Care Organizations ~~reports to enter~~for the VBP specifications and the appropriate LAN VBP category for each payment model ~~in the RFA VBP Data Template~~. The Technical Guide for Coordinated Care Organizations for the VBP specifications is located at the following URL:

<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx>

~~2.2.~~ Expanding VBP beyond primary care to other care delivery areas

- a. Contractor shall develop new, or expanded from existing contract, VBPs in care delivery areas which include ~~hospital~~Hospital care, maternity care, children's health care, ~~behavioral health~~Behavioral Health care, and ~~oral health~~Oral Health care. The term "expanded from an existing contract" includes, but is not limited to, an expansion of ~~a CCO~~Contractor's existing ~~contract~~contracts such that more ~~providers and/or members~~Providers or Members, or both Members and Providers, are included in the arrangement, ~~and/or~~ higher level VBP components are included (or both more Members and Providers are included in the arrangements and higher level VBP components are included). Prior to the ~~effective-date~~Coverage Effective Date of this Contract, Contractor will receive final specifications of care delivery area VBPs, including required reporting metrics, from OHA as well as the due date for the VBP Plan for Contract Year one (2020).

- b. Required VBPs in care delivery areas must fall within LAN ~~Category 2C (Pay for Performance) or higher through~~Category 2C (Pay for Performance) or higher throughout the ~~duration~~Term of ~~the CCO 2.0 period~~this Contract. Contractor shall ~~plan to~~ implement care delivery area VBPs, according to the following schedule:

- (1) In 2020, Contractor shall develop ~~two~~three (3) new or expanded VBPs. The ~~two~~three (3) new or expanded VBPs shall be in ~~two~~three of the listed care delivery areas, and one of the areas must be Behavioral Health care, and one of the two remaining care delivery areas must be either ~~hospital~~Hospital care or maternity care. ~~However, nothing precludes Contractor may design from designing new or expanded VBPs in both hospital~~Hospital care ~~and~~, maternity care, and Behavior Health care. A VBP may encompass two care delivery areas; e.g. a ~~hospital~~Hospital maternity care VBP that met specifications for both care delivery areas could count for both ~~hospital~~Hospital care and maternity care delivery areas.;
- (2) ~~(1) By~~Commencing on January 1, 2021, Contractor shall implement ~~two~~the three (3) new or expanded VBPs, ~~that were~~ developed ~~in previous years~~during Contract Year one (2020) under Sub. Para. (1) above of this Para. b, Sec. 2, Ex. H;
- (3) ~~(2) By~~Commencing on January 1, 2022, Contractor shall implement a new VBP in one additional care delivery area. By the end of 2022, new VBPs in ~~both hospital~~Hospital care, Behavioral Health care, and maternity care shall be in place.;
- (4) ~~(3) By 2023~~Commencing on January 1 2023 and then on January 1, 2024, Contractor shall implement one new VBP each year in each of the remaining care delivery areas.;
- (5) ~~(4) By~~ the end of 2024, Contractor shall implement new or expanded VBPs in all five care delivery areas.

3. Patient-Centered Primary Care Home (PCPCH) VBP requirements

- a. Contractor shall provide per-~~member~~Member-per-month (~~PMPM~~) payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they ~~fee~~Fee-for-serviceService or VBPs. Contractor shall also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The ~~PMPMs~~PMPM payments must be meaningful in amounts, ~~increasing~~ that are material and increase each ~~year over~~of the five-~~year~~Contract Years of this Contract.
- b. The PCPCH PMPM payment counted for this requirement must be at a LAN ~~Category 2A (Foundational Payments for Infrastructure & Operations)~~Category 2A (Foundational Payments for Infrastructure & Operations) level, as defined by the LAN Framework. Unless combined with a LAN Category 2C VBP or higher, ~~these such~~ payment arrangements ~~would~~shall not count toward ~~the Contractor's~~ annual CCO VBP minimum threshold or ~~CCO~~Contractor's annual VBP targets.

4. VBP Targets by Year

- a. Contractor must increase ~~annually~~ the level of ~~payments that are value based through~~VBPs each Contract Year during the ~~duration~~Term of ~~the CCO 2.0 period~~this Contract and must meet minimum annual thresholds, according to the following schedule:
- (1) For services provided in 2021, no less than thirty-five percent (35%) of Contractor's payments to ~~providers~~Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;

- (2) For services provided in 2022, no less than fifty (50%) of Contractor's payments to ~~providers~~Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;
- (3) For services provided in 2023, no less than sixty percent (60%) of Contractor's payments to ~~providers~~Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher, and no less than twenty percent (20%) of ~~the CCO~~Contractor's payments to ~~providers~~Providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards ~~the Contractor's~~ annual ~~CCO~~ VBP targets.
- (4) For services provided in 2024, no less than seventy percent (70%) of the CCO's payments to ~~providers~~Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher, and no less than twenty-five percent (25%) of ~~the CCO~~Contractor's payments to ~~providers~~Providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards ~~the Contractor's~~ annual ~~CCO~~ VBP targets.

5. Contractor VBP Data Reporting; Overview

Contractor shall categorize VBP arrangements and submit VBP data using ~~The Health Care Payment Learning and Action Network (LAN) categories and OHA Value-based Payment Roadmap Categorization Guidance~~the LAN categories and the OHA VBP Technical Guide for Coordinated Care Organizations to ~~categorize VBP arrangements~~Organizations for technical specifications as set forth below in Sections 6 through 9 below of this Exhibit H. Contractor shall implement the VBP plan Contractor submitted ~~as part of~~with its Application, or report deviations from such plan to OHA. Contractor shall comply with the following reporting requirements:

- a. OHA desires to ensure that linkage of quality to payment is accomplished with integrity both in terms of size of reward for performance and demonstration for excellence and meaningful improvement to receive the awards. As outlined above, OHA ~~may ask~~has the right to require Contractor to provide detailed information on the size of the ~~incentive payment within the overall contract to ensure~~VBPs made pursuant to the terms and conditions of this Contract for the purposes of ensuring that ~~there~~Contractor is implementing meaningful ~~level~~levels of ~~incentive to the provider to improve~~incentives, such that Providers are being encouraged and rewarded for improving overall quality performance. Contractor shall describe the specific quality metrics ~~from utilizing the HPQMC Aligned Measures Menu, or~~HPQMC Aligned Measures Menu, which is located at the following URL:

<https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee.aspx>

- (1) In the event OHA develops an HPQMC Core Measure Set, Contractor shall use such Measure Set for identifying benchmarks and other relevant criteria for VBPs.
- (2) For VBP arrangements that involve Behavioral Health services, Contractor shall additionally use Exhibit M to the Contract for guidance in making metric selection.
- (3) If Contractor determines that the HPQMC Aligned Measures Menu, or if and when developed, the HPQMC Core Measure Set, ~~if developed in future years, that will be used, including the established benchmarks that will be used for performance-based payments to providers and other relevant details; or if the aligned measure set does~~do not include appropriate metric~~(s)~~ for planned ~~VBP~~VBPs, or the measures are not aligned, Contractor

may request approval from OHA to use other metrics, preferably those defined by the National Quality Forum ~~(NCF)~~or similar national measure steward.

(a) Such requests shall be made via Administrative Notice and submitted to the following email address: OHA.VBP@dhsoha.state.or.us

(b) Such requests must be accompanied by Contractor's rational for proposing different metrics or measures. Such requests will be approved by OHA provided that the rational for Contractor's proposed metrics or measures (or both) are both related and designed to advance the Triple Aim goals of improving quality of care, health care outcomes for Members, and lowering costs.

b. ~~Should~~In the event (i) OHA contract~~contracts~~ with one or more ~~other~~ CCOs serving ~~members~~Members in the same ~~geographical area~~Service Area, and (ii) Contractor and such other CCO(s) shall participate in OHA-facilitated discussions to select performance measures ~~to be incorporated~~and any other areas of alignment that Contractor and such CCO(s) shall incorporate into each CCO's of the their VBP provider~~Provider~~ contracts for the common ~~provider~~Provider types and specialties. OHA ~~shall~~will inform ~~the~~ Contractor, , via Administrative Notice to Contractor's Contract Administrator, of the ~~provider~~Provider types and specialties ~~for~~that will be subject to the foregoing discussions. Upon conclusion of such discussions, OHA shall notify Contractor, via Administrative Notice to Contractor's Contract Administrator, which—the performance measures shall be discussed.—Each Contractor and the other CCO ~~shall~~(s) must incorporate all selected measures into their applicable provider~~Provider~~ contracts.

c. OHA shall have the right to request additional reporting of VBP arrangements to substantiate Contractor's timely achievement of VBP requirements.

d. OHA shall have the right to use data submitted with Contractor's Exhibit L Financial Report to validate Contractor's VBP data submissions or for any other purpose related to OHA VBP programs or policies that may be implemented in accordance with the terms and conditions of this Contract.

6. VBP Data Reporting: Contract Year 2020

a. If Contractor and OHA were parties to a Predecessor Agreement that expired on December 31, 2019, Contractor shall provide OHA VBP data to OHA as set forth in para. b below of this Sec. 6, Ex. H. If Contractor was not a party to a Predecessor Agreement, Contractor does not have any VBP reporting obligations under this Sec. 6 of Exhibit H.

b. ~~e. By~~If Contractor was a party to a Predecessor Agreement as stated in Para. a above of this Sec. 6, Ex. H, Contractor shall, by no later than September 30, 2020, Contractor shall—submit payment~~VBP~~ arrangement data to OHA via the APAC's—Appendices G and H. Please see Payment Arrangement File and Payment Arrangement Control File (currently known as Appendix 1 and 2, respectively) which is located at:

(4) Additional information regarding Contractor's reporting obligations under this Section 6, Ex. H can be found in the APAC Reporting Guide located at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx>.

7. Interviews: VBP Arrangements and Data Reporting ~~Guide for addition information.~~

~~Report PCPCH VBP details including:~~

- ~~(1) — Payment differential and/or range across the PCPCH tier levels during year CY-1 Contract Year One (2020);~~
- ~~(2) — Proposed payment differential and/or range by PCPCH tier levels over CY-1(2020) through CY2 (2021);~~
- ~~(3) — Rationale for approach (including factors used to determine the rate such as rural /urban, social complexity).~~
- ~~(4) — How the payments meaningfully support clinics' efforts to support patient-centered care.~~

a. ~~d.~~ By Spring/Summer~~In June of~~ 2020, Contractor's executive leadership team shall engage in interviews with OHA to:

- (1) Describe how the ~~first year of~~ activities and VBP arrangements during Contract Year one (2020) compare to that which was ~~reported~~submitted in the Application Contractor submitted in response to the RFA, including detailed information about VBP arrangements and LAN categories;
- (2) Discuss the outcome of ~~the~~ Contractor's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was ~~reported in the RFA~~included in the Application Contractor submitted in response to the RFA and those relating to VBP arrangements with Providers serving populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;
- (3) Report implementation plans for the two care delivery areas that will ~~start~~be implemented in Contract Year two (2021); and
- (4) Any additional information requested by OHA on VBP development and implementation.

~~OHA may~~

8. VBP Data Reporting: Contract Year Two (2021)

a. By no later than February 15, 2021, Contractor must complete and provide to OHA the VBP Targets and PCPCH Data Template. Utilizing the VBP Targets and PCPCH Data Template, Contractor shall include summary data stratified by LAN categories which describes Contractor's VBP arrangements during Contract Year one (2020). In the event not all adjudicated payments made for 2020 will be available for inclusion in the February 15, 2021 report, Contractor shall report all Fee-For-Service payments that are associated with a VBPs for the purpose of enabling Contractor and OHA to assess Contractor's preliminary progress toward meeting VBP targets. Providing OHA with data related to FFS payments before all data is available will function as a rolled-up version of Contractor's APAC Payment Arrangement File submission and will enable OHA to more effectively Monitor Contractor's progress toward achieving VBP targets. The February 15, 2021 report will also serve as a comparison to the data included in the Application that Contractor's submitted in response to the RFA.

b. In June of Contract Year two (2021), Contractor's executive leadership team must engage in interviews with OHA to:

- (1) Describe the activities regarding the VBP arrangements during Contract Year one (2020);

- (2) Discuss the outcome of the Contractor’s plan for mitigating adverse effects of VBPs on populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;
 - (3) Report outcomes to date of the two care delivery areas implemented in January of 2021;
 - (4) Report implementation plans for the new care delivery area/s for Contract Year three (starting in January of 2022); and
 - (5) Any additional information requested by OHA on VBP development and implementation.
- c. By no later than September 30, 2021 Contractor must submit VBP data via APAC’s Payment Arrangement File and Payment Arrangement Control File for the previous calendar year. Contractor should note that OHA shall utilize the Data submitted to the APAC Payment Arrangement File and Payment Arrangement Control File, which allows for a nine-month lag after the reported time period, to determine whether Contractor has met its CCO’s VBP targets.

9. VBP Data Reporting: Contract Years 2022-2024

Contractor’s VBP data reporting obligations for Contract Years three (2022) through five (2024) shall include all of the following:

- a. By no later than February 15 of Contract Years three through five, Contractor must submit the Care Delivery Area VBP data template, which includes summary data stratified by LAN categories that describes contractor’s payment arrangements implemented in the required care delivery areas (CDAs);
 - b. Contractor must engage in interviews with OHA during the month of June as detailed in Para. b, Secs. 7 and 8 above of this Ex. H.
 - c. Contractor must provide to OHA, by no later than September 30, VBP data via APAC’s Payment Arrangement File and Payment Arrangement Control File for each of the previous Contract Years.
- (1) Due to the timing of data availability, Contractor’s VBP data reporting obligations for Contract Years four and five (2024) shall survive termination of this Contract. Accordingly, Contractor shall submit to OHA such delayed data for Contract Years four and five via by no later than, as applicable, February 15 of 2025 and 2026. Such data shall be submitted to OHA in accordance with Para. a above of this Sec. 9, Ex. H.

10. Transparency and VBP Data

OHA will publish ~~each~~ Contractor’s VBP data, such as the actual VBP percent of spending ~~that is LAN category 2C or higher~~ and ~~spending that is LAN category 3B or higher~~, as well as data pertaining to the Contractor’s care delivery areas, PCPCH payments, and other information pertaining to VBPs. Notwithstanding the foregoing, OHA will not publish specific payments amounts ~~from an made by a~~

Contractor to a specific ~~provider~~Provider or any other data, whether in raw or aggregate form, that could result in a disclosure of Contractor's Trade Secrets as such term is defined under ORS 192.345.

[Remainder of page intentionally left blank]

Exhibit I – Grievance and Appeal System

~~Contractor shall establish and maintain a system for Members, supported by written policies and procedures, under which a Member, or a representative acting on his or her behalf, may challenge any Adverse Benefit Determination made by the Contractor, as defined in 42 CFR 438.400 and file a grievance for any matter other than an Adverse Benefit Determination. Contractor shall maintain its Member's~~ Grievance and Appeal System ~~in accordance with this exhibit, OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.424. Grievance and appeal system means~~consists of the processes the Contractor implements for ~~grievances~~Grievances, Adverse Benefit Determinations, ~~appeals~~Appeals of ~~an adverse benefit determination~~Adverse Benefit Determinations, resolutions of Appeals, and access to ~~contested case hearing~~Contested Case Hearing, as well as the processes to collect and track information about ~~them~~these processes. Contractor shall create, implement, and maintain a written Grievance and Appeal System setting forth Contractor's policies, procedures, and processes that Contractor and Members shall follow when addressing a Member's Grievance or Appeal. The Grievance and Appeal System shall include, without limitation, a Grievance process, an Appeal process, and access to Contested Case Hearings in accordance with OAR 410-141-3247 and OAR 410-120-1860. Contractor's Grievance and Appeal System shall meet the requirements in OAR 410-141-3225 through 410-141-3255, and 42 CFR §438.400 through §438.424, this Exhibit I, and any other applicable provisions of this Contract. Contractor's Grievance and Appeal System shall provide for processes by which a Member may challenge any oral or written Adverse Benefit Determination made by the Contractor, or by which a Member may file a Grievance for any matter other than an Adverse Benefit Determination. Contractor's Grievance and Appeal System shall be included in all Member Handbooks and in Contractor's Provider Handbook and on Contractor's Provider website. For the purposes of this Exhibit I, references to "Member" means a ~~member, the member's representative, a provider~~Member as defined in OAR 410-141-3320 or a Provider acting on behalf of ~~the member~~a Member and with ~~member~~Member's written consent, ~~or a representative of a deceased member's estate~~. Contractor's Grievance and Appeal System shall be subject to review and approval by OHA as set forth in Ex. I, Sec. 10 of this Contract.

1. Grievance and Appeal System – Requirements

~~Contractor have~~

2.

- a. Without limiting any other provisions in this Exhibit I or this Contract regarding Contractor's Grievance and Appeal System, Contractor's Grievance and Appeal System shall:
 - (1) Include only one level of ~~appeal~~Appeal for ~~members~~Members; and ~~members must~~
 - (2) Require that Members complete the ~~appeals~~Appeals process with ~~the CCO~~Contractor prior to requesting a ~~state~~Contested Case Hearing.
- b. Without limiting any other provisions in this Exhibit I or this Contract regarding Contractor's obligations with respect to its Subcontractors' and Participating Providers, Contractor shall:
 - (1) Cause its Participating Providers and Subcontractors to comply with the Grievance and Appeal System requirements set forth in this Exhibit I, and any other applicable provisions of this Contract.
 - (2) Provide to all Participating Providers and Subcontractors, at the time they enter into a Subcontract, written notification of procedures and timeframes for Grievances, Notice of Adverse Benefit Determination, Appeals, and Contested Case Hearings as set forth in this Exhibit I, and shall provide all of its Participating Providers and Subcontractors written

notification of updates to these procedures and timeframes within five (5) Business Days after approval of such updates by OHA.

- (3) Monitor the compliance of Contractor's Subcontractor and Provider Network with all Grievance and Appeal requirements outlined in federal and State law and the provisions of this Contract.

c. ~~a.~~ Filing Requirements. Contractor's Grievance and Appeal System must provide that Members shall have the right to:

- (1) ~~A Member may file~~File a Grievance or an Appeal with the Contractor;~~;~~.
- (2) ~~A Member may file~~File a Grievance with OHA or the Contractor. If a Member files a Grievance with OHA, OHA will promptly send the Grievance to the Contractor; to address in accordance with Contractor's Grievance and Appeal System.
- (3) ~~A Member may request~~Request a Contested Case Hearing with OHA after receiving notice that ~~an Appeal to~~ Contractor ~~Appeal~~ has been upheld, except where Contractor fails to adhere to the notice or timing requirements in 42 CFR 438.408, ~~thein which case~~ Member is deemed to have exhausted the Contractor's ~~appeals~~Grievance and Appeals System process. ~~The and~~ Member may ~~initiate a hearing~~request a Contested Case Hearing.

d. ~~b.~~ Timing. Contractor's Grievance and Appeal system must provide that Members shall have the right to:

- (1) ~~A member may file a grievance~~File a Grievance at any time for any matter other than an Adverse Benefit Determination.
- (2) ~~A member may file~~File an Appeal within sixty (60) days from the date on the ~~Notice of Adverse Benefit Determination~~NOABD.
- (3) ~~A member may request~~Request a Contested Case Hearing with either Contractor or OHA within one hundred and twenty (120) days from the date on the Notice of Appeal Resolution when Contractor's ~~adverse benefit determination~~Adverse Benefit Determination is upheld or, ~~if the Authority dees~~date that OHA deems that the Member has exhausted the Contractor's ~~appeals~~Appeals process.

e. ~~e.~~ General System Requirements

- (1) Contractor shall permit Member to file a Grievance ~~either orally or in writing; and at~~ Member's option.
- (2) Contractor shall permit Member to file an Appeal ~~either orally or in writing,~~ consistent with the requirements in OAR 410-141-3245.
- (3) Contractor shall ~~ensure~~treat an oral ~~requests~~request for ~~appeal~~Appeal of an ~~adverse benefit determination are treated as appeals to~~Adverse Benefit Determination as an Appeal and shall establish the ~~earliest possible~~filing date; ~~as the date of the oral request.~~
- (4) Contractor shall ~~Provide~~provide Members reasonable assistance in completing forms and taking other procedural steps in connection with Grievances, Appeals, and Contested Case Hearings. This assistance ~~includes~~must include, 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;~~The CCO free of charge to each Member.~~

- (5) ~~Contractor~~ shall not discourage a ~~member~~Member from using any aspect of the ~~grievance system~~Grievance and Appeal System, encourage Member's withdrawal of a Grievance, Appeal, or Contested Case Hearing request already filed, use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a Member or request Member Disenrollment, or take punitive action against a ~~provider~~Provider who requests an expedited resolution or supports a ~~member~~Member's ~~grievance~~Grievance or ~~appeal~~Appeal.
- (6) ~~(5)~~ Contractor shall make ~~grievance~~Grievance and ~~appeal~~Appeal forms, including those listed in OAR 410-141-3230 (11), available and accessible to ~~members~~—~~(OAR-410-141-3230)~~Members in all administrative offices.
- (7) ~~(6)~~ Individuals who make decisions on ~~grievances~~Grievances and ~~appeals~~—~~whether employed directly by the Contractor or through a subcontractual agreement,~~Appeals must be individuals—who:
- (a) ~~Who were neither~~Were not involved in any previous level of review or decision-making ~~nor~~with respect to the Grievance or Appeal;
- (b) Were not a subordinate of ~~any such an~~an individual ~~involved in any previous level of review or decision-making with respect to the Grievance or Appeal;~~ and
- (c) ~~(b)~~ ~~Who, if~~If deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the ~~enrollee~~Member's condition or disease:
- i. An ~~appeal~~Appeal of a denial that is based on lack of medical necessity;
 - ii. A ~~grievance~~Grievance regarding denial of expedited resolution of an ~~appeal~~Appeal; or
 - iii. A ~~grievance~~Grievance or ~~appeal~~Appeal that involves clinical issues.
- (8) ~~(7)~~ Contractor's Appeal process shall take into account all comments, documents, records, and other information submitted by ~~the~~ Member ~~or their representative~~ without regard to whether such information was submitted or considered in the initial ~~adverse benefit determination~~Adverse Benefit Determination.
- (9) ~~(8)~~ If ~~the~~ Contractor delegates part of the ~~grievance and appeal~~Grievance process to a ~~subcontractor or participating provider~~Subcontractor or Participating Provider, ~~the~~ Contractor must with respect to any part of the process delegated:
- (a) i. Validate that ~~the subcontractor~~performance of Subcontractor or Participating Provider meets the requirements ~~consistent with~~of this ~~rule and~~Contract, OAR 410-141-3225 through 410-141-3255, and 42 CFR 438.400 through 410-141-3255;438.424.
- (b) ii. Monitor ~~the subcontractor~~Subcontractor's or Participating Provider's performance on an ongoing basis;

- ~~(c)~~ ~~iii.~~—Perform a formal compliance review of Subcontractor or Participating Provider at least annually to assess performance, deficiencies, ~~or~~and areas for improvement;~~and.~~
- ~~(d)~~ ~~iv.~~—Cause ~~subcontractor~~Subcontractor or Participating Provider to take ~~corrective action~~Corrective Action for any identified areas of deficiencies that need improvement.
- ~~(e)~~ ~~v.~~—Include data collected by ~~subcontractors~~Subcontractors or Participating Providers in ~~its~~Contractor's analysis of ~~grievance~~Grievance system provided to OHA, and ensure data is reviewed by Contractor's Compliance Committee, consistent with contractual requirements for CCO quality improvement.

~~(10)~~ ~~(9)~~—Contractor shall not delegate ~~Adjudication of an Appeal~~ to a Subcontractor or Participating Provider the adjudication of an Appeal, in accordance with OAR 410-141-3230 (4).

2. Grievances~~Grievances~~. In addition to the general system requirements set forth in Ex. I, Sec. 1, Para. e. of this Contract, Contractor's Grievance and Appeal system must provide for the following:

- ~~a.~~—~~Contractor shall permit a member may file a grievance at any time, orally or in writing with the CCO or OHA; who will promptly send the grievance to the CCO. Grievance includes a Member's right to dispute an extension of time proposed by the contractor or its delegates to make an authorization decision.~~
- ~~a.~~ ~~b.~~—Upon receipt of a grievanceGrievance, the Contractor shall comply with grievanceGrievance process and timing requirements in OAR 410-141-3230~~and~~, 410-141-3235 and 42 CFR 438.408.
- ~~b.~~ ~~e.~~—Contractor's notice of grievanceGrievance resolution shall comply with OHA's formattingformat requirements and readability standards in OAR 410-141-3300 and 42 CFR §438.10.
- ~~d.~~—~~A member grievance that involve a clinical issue or a denial based on medical appropriateness or medical necessity, or for denial of an expedited appeal resolution, must be reviewed by individuals with appropriate clinical expertise, as determined by OAR 410-141-3230 in treating the enrollee's condition or disease.~~
- ~~c.~~ ~~e.~~—~~A member grievance~~Upon receipt of a Member Grievance related to ~~a member~~Member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one CCO to another CCO ~~for reasons~~as defined in OAR 410-141-3080 (15), 3061, Contractor shall ~~be recorded by~~record the ContractorGrievance and ~~the Contractor shall~~ work with the receiving, or sending, CCOContractor to ensure continuityContinuity of careCare during the transition.
- ~~d.~~ ~~f.~~—Contractor shall promptly cooperate and cause ~~it subcontractor~~its Subcontractor to promptly cooperate, with the investigations and resolution of a Grievance by the CSU~~either~~ or both DHS' Client Services Unit and OHA's ~~Ombudsman, timely;~~Ombudsperson as expeditiously as the enrolleeMember's health conditions required, and no longer the State.~~established~~condition requires, and within timeframes set forth in the contract or required by this Contract.
- ~~e.~~ ~~g.~~—~~The CCO~~Contractor shall ~~address the~~conduct analysis of its grievancesGrievances in the context of quality improvement activity, consistent with OAR 410-141-3230 and incorporate the analysis into ~~contract deliverables~~the quarterly data provided to OHA under this Contract.

~~f. h. The CCO Contractor~~ must resolve each ~~grievance~~Grievance and provide notice ~~to the Member~~ of the disposition as expeditiously as the ~~member~~Member's health condition requires ~~but no later than~~within the following timeframes ~~and meeting the following requirements:~~

(1) Resolution for Grievances

~~Notify. Contractor shall provide written notice to~~ the Member, within five ~~(5)~~5 Business Days from the date of the Contractor's receipt of the Grievance, ~~acknowledging receipt of the Grievance and~~ of one of the following:

- (a) A decision on the Grievance has been made and what that ~~decisions~~decision is; or
- (b) ~~That there~~Contractor's decision will ~~be a delay in~~not exceed thirty (30) calendar days from the date of Contractor's ~~decision, of up to 30 days. The written notice shall specify why~~receipt of the Grievance, and the reason additional time is necessary.

(2) ~~Notice of Grievance Resolution~~ Notice Requirements

- (a) Contractor shall respond ~~in writing~~ to all Member ~~grievances. In addition to written response, the Contractor~~Grievances in writing with a notice of Grievance resolution, and may also respond orally.
- (b) ~~Notice~~Contractor's notice of Grievance resolution shall address each aspect of the Member's Grievance and explain the reason for ~~the~~ Contractor's decision.
- (c) ~~Notice~~The language ~~in Contractor's notice of Grievance resolution~~ shall be sufficiently clear that a layperson could understand the disposition of the ~~grievance and the process for members who are dissatisfied to present the grievance to the Department of Human Services (DHS) Client Services Unit or OHA's Ombudsman~~Grievance.
- (d) ~~Notice~~The notice of Grievance resolution shall include information ~~on~~sufficiently clear that a layperson could understand how a Member who is dissatisfied with the ~~disposition of a grievance~~decision may present the Grievance to OHP Client Services Unit (CSU) toll free at 800-273-0557 or OHA's ~~Ombudsman~~Ombudsperson at 503-947-2346 or toll free at 877-642-0450.

3. Notice of Adverse Benefit Determination - Requirements

4.

When Contractor has made or intends to make ~~and adverse benefit determination~~an Adverse Benefit Determination the Contractor shall notify the requesting Provider and mail ~~to the Member a~~ written Notice ~~to the Member~~of Adverse Benefit Determination.

a. Contractor ~~Notice format's~~ NOABD must ~~be reviewed and approved by OHA prior to use.~~comply with all of the following requirements:

(1) ~~b. Contractor shall only use OHA approved Notice format. The Notice shall meet~~Meet the language and format requirements in ~~Exhibit Ex.~~ B, Part 3, ~~Section~~Sec. 4 and be consistent with the requirements of OAR 410-141-3280, 410-141-3300 and 42 CFR §438.10. ~~Contractor written notice shall be~~

- (2) Be translated for Members who speak prevalent non-English languages, as ~~defined~~
~~in required by~~ 42 CFR 438.10 (c), ~~and~~;
- (3) Include all ~~notices must include language of~~ the following information:
- (a) Language clarifying that oral interpretation is available for all languages and how to access it, ~~and include at a minimum the following information~~;
- (1) ~~(b)~~ Date of the notice;
- (2) ~~(c)~~ Contractor name, address and phone number;
- (3) ~~(d)~~ Name of the ~~member~~Member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or ~~behavioral health~~Behavioral Health professional, as applicable;
- (4) ~~(e)~~ Member's name, address and ID number;
- (5) ~~Service~~(f) Description and explanation of the service(s) requested or previously provided and ~~adverse benefit determination the MCE~~an explanation of the Adverse Benefit Determination that Contractor made or intends to make, including whether ~~the MCE~~Contractor is denying, terminating, suspending, or reducing a service or ~~denial of~~denying a payment for a service in whole or in part;
- (6) ~~(g)~~ Date of the ~~Service~~service or date service was requested by the ~~provider~~Provider or ~~member~~Member;
- (7) ~~(h)~~ Name of the ~~provider~~Provider who performed or requested the service;
- (8) ~~(i)~~ Effective date of the ~~adverse benefit determination~~Adverse Benefit Determination if different from the date of the ~~Notice~~NOABD;
- (9) ~~Whether~~(j) Other conditions the ~~CCO~~Contractor considered ~~other conditions such as~~including but not limited to co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services; statement of intent governing the use and application of the Prioritized List to requests for health care services; and other coverage for services addressed in the State's 1115(a) Waiver.
- (k) Clear and thorough explanation for the specific reasons for the ~~adverse benefit determination reason~~Adverse Benefit Determination;
- (10) ~~(l)~~ A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the ~~Notice~~NOABD;
- (11) ~~(m)~~ The Member's right to file an Appeal, and the procedures to exercise that right;
- (12) ~~(n)~~ The Member's right to request a Contested Case Hearing, and the procedures to exercise that right;
- (13) ~~(o)~~ The circumstances under which an expedited Appeal resolution and an expedited Contested Case ~~hearings~~hearing are available and how to request;
- (14) ~~(p)~~ The Member's right 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;

~~(15)~~ (q) The Member's right to ~~be provided~~receive from Contractor, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's Adverse Benefit Determination; and;

~~(16)~~ ~~Contractor shall include with Notice~~ (r) Copies of the appropriate forms as ~~outlined~~listed in OAR 410-141-3240 ~~(2)~~.

b. ~~e.~~ Contractor shall, for every NoticeNOABD, meet the following timeframes:

- (1) For termination, suspension, or reduction of previously authorized Covered Services:
- (a) The NoticeNOABD shall be mailed at least ten (10) days before the date of the Adverse Benefit Determination ~~takes effect~~, except as permitted under ~~Items~~Ex. I, Sec. 3, Para. c, Sub. Para. Sub. Para. (1) (b) ~~or~~and (c) ~~below~~.
- (b) The ~~Notice shall~~NOABD may be mailed ~~not less than ten (10) days prior to, but in no event~~ later than the date of the Adverse Benefit Determination takes effect if:
- i. ~~(i)~~ Contractor has factual information confirming the death of the Member;
 - ii. ~~(ii)~~ Contractor receives a clear, written statement signed by the Member that ~~he or she~~the Member no longer wishes services or gives information that requires termination or reduction of services and indicates that ~~he or she~~the Member understands that ~~this must~~termination or reduction of services will be the result of supplying the information;
 - iii. ~~(iii)~~ Contractor can verify the Member has been admitted to an institution where ~~he or she~~the Member is ineligible for Covered Services from the Contractor;
 - iv. ~~(iv)~~ The Member's whereabouts are unknown and the Contractor receives a notice from the post office indicating no forwarding address and ~~the Authority or Department~~OHA has no other address;
 - v. ~~(v)~~ The Contractor verifies another state, territory, or commonwealth has accepted the Member for Medicaid services;
 - vi. ~~(vi)~~ The ~~member~~Member's PCP, PCD, or ~~behavioral health~~Behavioral Health professional prescribed a change in the level of ~~medical care that is prescribed by the Member's Provider~~health services;
 - vii. ~~(vii)~~ There is an ~~adverse determination~~Adverse Benefit Determination made with regard to the preadmission screening requirements for LTPC admissions; or
 - viii. ~~(viii)~~ TheFor Adverse Benefit Determinations for LTPC transfers, 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 thirty (30) days ~~(applies only to adverse Actions for LTPC transfers)~~.
- (c) The NoticeNOABD shall be mailed not less than five (5) days before the date of the Adverse Benefit Determination when the Contractor has facts indicating that an Adverse Benefit Determination should be taken because of probable Fraud on

the part of the ~~Members~~Member, and ~~whenever possible, the~~ Contractor has verified those facts ~~should be verified, if possible,~~ through secondary sources.

- (2) For denial of payment, the ~~Notice~~NOABD shall be mailed at the time of any ~~Action~~Adverse Benefit Determination 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 and are standard authorization decisions:
- (a) The ~~Notice~~NOABD shall be mailed as expeditiously as the Member's health condition requires and ~~within 14~~in all cases not later than fourteen (14) calendar days following receipt of the request for service, except that:

- i. ~~(i)~~ The Contractor may have an extension of up to fourteen (14) additional calendar days if the Member or the Provider requests the extension; or if the when Contractor justifies (to OHA upon request) can justify that a need for additional information and how the extension is in the Member's interest; Contractor must provide its justification to OHA, via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request;
- ii. ~~(ii)~~ If the Contractor extends the timeframe, in accordance with ~~Item~~SSP (i) above, it of this Ex. I, Sec. 3, Para. c, Sub. Para.(1) (a) (3), Contractor shall give the Member written notice, and shall make reasonable effort to give the Member oral 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 the Member disagrees with that decision.
- iii. ~~(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~~any extension expires.

- (4) For Prior Authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested and are expedited authorization decisions:

- (a) The NOABD shall be mailed as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours following receipt of the request for service, except that:

- i. Contractor may have an extension of up to fourteen (14) additional calendar days if the Member or the Provider requests the extension or when Contractor can justify that a need for additional information and that the extension is in the Member's interest; Contractor must provide its justification to OHA, via Administrative Notice to an email address identified by OHA in its request, within five (5) days of OHA's request.;
- ii. If Contractor extends the timeframe, in accordance with SSP (i) above of this Ex. I, Sec. 3, Para. c, Sub. Para. Sub. Para. (1) (a) (3), Contractor shall give the Member written notice, and shall make reasonable effort to give the Member oral notice of the reason for

the decision to extend the timeframe and inform the Member of the right to file a Grievance if the Member 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 any extension expires.

~~(5) For~~ (5) A NOABD for a Prior Authorization decision not reached within the appropriate timeframes ~~(which constitutes a adverse benefit determination); the Notice~~ shall be mailed on the date that the ~~Authorization~~ timeframe expires;

5. Handling of Appeals.

Contractor shall have written policies and procedures for Contractor's Grievance and Appeal System that meet the requirements of OAR 410-141-3230, 410-141-3245 and 410-141-3246 and address how ~~the CCO~~Contractor will accept, process, and respond to Appeals. ~~Contractor shall have one level of Appeal for Members.~~

a. General Requirements Policies and Procedures Required.

In addition to the requirements set forth in Ex. I, Sec. 1, and OAR 410-141-3230, 410-141-3245 and 410-141-3246, Contractor's Grievance and Appeal System shall also include policies and procedures to:

~~(1) Contractor shall acknowledge receipt of each Appeal;~~ Acknowledge to Member receipt of each non-expedited Appeal in writing within five (5) Business Days of receipt, and of each expedited Appeal orally or in writing within one (1) Business Day of receipt.

~~(2) Contractor procedures shall require that Individuals who make decisions on Appeals are individuals:~~

~~(a) Who were not involved in any previous level of review or decisions making;~~

~~(b) Who are not subordinates of any individual involved in a previous level of review or decision making; and~~

~~(c) Who, if deciding any of the following, are Health Care Professionals as defined in OAR who have the appropriate physical health, behavioral health (which includes mental health and Substance Use Disorders), and oral health clinical expertise, in treating the Member's condition or disease:~~

~~(i) An Appeal of a denial that is based on lack of Medically Appropriate services;~~

~~(ii) An Appeal that involves clinical issues.~~

~~b. Requirements for Appeals~~

~~Contractor process for Appeals shall:~~

- (2) ~~(1) Provide that oral inquiries seeking~~Require Member to submit a written Appeal ~~an~~ Action are treated as Appeals, in order to establish the earliest possible filing date, and must be confirmed in writing~~after filing an Appeal orally~~, unless the Member ~~or the Provider~~ requests an expedited resolution as provided by OAR 410-141-3245(6)(a).
- (3) ~~(2) Provide the Member a reasonable opportunity to present evidence and~~ allegations of fact or law, make legal and factual arguments in person as well as in writing as provided by OAR 410-141-3245 (7)(h). ~~The~~ Contractor shall inform the Member of the ~~limited amount of~~ time available to present evidence and argument sufficiently in advance of the resolution timeframe for ~~appeals~~Appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.
- (4) ~~(3) Provide~~Upon request, provide the Member, ~~upon request with~~ a copy of the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by ~~the CCO~~Contractor (or at the direction of ~~the CCO~~Contractor) in connection with the ~~appeal~~Appeal of the ~~adverse benefit determination~~Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for ~~appeals~~Appeals as specified in 42 CFR §438.408 (b) and (c).
- (5) ~~(4) Contractor shall provide~~Provide Appeal information to Members in accordance with Exhibit B, Information Materials and Education of Members and Potential Members, and, at a minimum provide the Member with the following information:
- (a) The ~~sixty (60-)~~ day time limit for filing an Appeal;
 - (b) The toll-free numbers that the Member can use to file ~~a Grievance or an~~ Appeal by phone;
 - (c) The availability of assistance in the filing process;
 - (d) The process to request a Contested Case Hearing after an Appeal;
 - (e) The rules that govern representation at the hearingContested Case Hearing; and
 - (f) ~~(e)~~ The right to have an ~~Attorney~~attorney or Member Representative present at the hearingContested 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~~;~~.
- (6) ~~(5) Contractor shall include~~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.
- (7) ~~(6)~~ The Contractor must document ~~appeals~~ and maintain a record of each Appeal as described in OAR 410-141-3245.

b. e. Appeal Resolution and Notification

(1) General Requirements for Resolution

(a) Contractor shall resolve each Appeal, and provide notice to the Member, as expeditiously as the Member's health condition requires and within the timeframes in this ~~section~~Ex. I, Sec. 4.

~~(b) — Adjudication of member Appeals must be performed by the Contractor. Adjudication may not be delegated or subcontracted; and~~

~~(b)~~ ~~(e)~~ If Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, ~~the member is considered~~Contractor must consider the Member to have exhausted the Appeals process and ~~may allowed to~~ initiate a ~~contested case hearing~~Contested Case Hearing.

(2) Standard Resolution for Appeals

(a) Contractor shall resolve ~~Standard~~standard Appeals as expeditiously as the Member's health condition requires and no later than sixteen (16) days from the day the Contractor receives the Appeal. The Contractor may extend this timeframe by up to fourteen (14) days if:

i. ~~(a)~~ The Member requests the extension; or

ii. ~~(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.

(b) If the Contractor extends the timeframes, it shall, for any extension not requested by the Member, give the Member a written notice, and make reasonable effort to give the Member oral notice of the reason for the delay.

(c) Contractor shall resolve ~~appeal~~all Appeals that have been granted extensions of time for resolution no later than the expiration date of the extension.

(3) Expedited Resolution for Appeals

(a) ~~The Member~~Members may file an expedited Appeal either orally or in writing. ~~(a)~~ For cases in which a Provider indicates, or the Contractor determines, that following the standard Appeal 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.

(b) Contractor shall resolve expedited Appeals ~~;~~ as expeditiously as the Member's health condition requires; and no later than seventy-two (72) hours from when the Contractor received the request for an expedited Appeal.

(c) The Contractor may extend the timeframe by up to fourteen (14) days if:

i. ~~(i)~~ The Member requests the extension; or

ii. ~~(ii)~~ The Contractor shall show (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 within in two (2) days of the reason for the delay, and make reasonable effort to give the Member oral notice. The Member has the right to file a ~~grievance~~Grievance if they disagree with the

extension. Contractor shall resolve ~~appeal~~Appeal no later than the expiration date of the extension.

- (e) If the Contractor denies a request for an expedited Appeal, the Contractor shall:
- i. ~~(i)~~—Transfer the Appeal to the time frame for standard resolution. Contractor shall resolve the ~~appeal~~Appeal no later than ~~sixteen (16)~~ sixteen (16) days from the day the Contractor receives the Appeal with possible ~~fourteen (14)~~ fourteen (14) day extension in accordance with OAR 410-141-3246; and
 - ii. ~~(ii)~~—Make reasonable efforts to give the Member prompt oral notice of the denial, and follow-up within two (2) days with a written notice. The written notice must state the right of a Member to file a ~~grievance~~Grievance with ~~the CCO~~Contractor if ~~he or she disagrees~~they disagree with that decision
- (f) If ~~the contractor~~Contractor approves a request for expedited ~~appeal~~Appeal but denies the services or items requested in the expedited ~~appeal, the CCO~~Appeal, Contractor shall:
- i. ~~(i)~~—Inform the ~~member~~Member of their right to request an expedited Contested Case Hearing and send the ~~member~~Member a Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-~~3247~~.
- ~~(g) — Contractor shall ensure that punitive action is neither taken against a Provider who requests and expedited resolution or supports a Member's Appeal~~3245.

(4) Notice of Resolution of Appeals

Contractor ~~notice's~~ Notice of ~~resolution~~Appeal Resolution shall be in a format approved by OHA and written in language that, at a ~~minimum~~minimum, ~~meet~~meets the standards described in 42 CFR §438.10. For notice of an expedited resolution, Contractor shall make reasonable effort to also provide oral notice. The written ~~notice~~Notice of ~~resolution of an~~ Appeal Resolution shall include the following:

- (a) ~~(a)~~—The results of the resolution process and the date the Contractor completed the resolution;
- (b) ~~(b)~~—For Appeals not resolved wholly in favor of the Member:
 - i. ~~(i)~~—Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the ~~appeal~~Appeal.
 - ii. ~~(ii)~~—The right of the Member to request a standard or expedited Contested Case Hearing with OHA within one hundred and twenty (120) days from the date of the Contractor's Notice of Appeal Resolution and how to do so, which includes sending the Notice of Hearing Rights (DMAP 3030) available at https://aix-xweb1p.state.or.us/es_xweb/FORMS/ and the Hearing Request Form (MSC 0443);
 - iii. ~~(iii)~~ or Appeal and Hearing Request (OHP 3302) available on the OHA Website at: <https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx>

- iv. The right to continue to receive benefits pending a Contested Care Hearing and how to do so;
 - v. ~~(v)~~ Information explaining ~~how~~that if the Contractor's Adverse Benefit Determination is upheld in a Contested Case Hearing, the Member may be liable for the cost of any continued benefits.
- (c) In the event an Appeal of an Adverse Benefit Determination proceeds to a Contested Case Hearing, Contractor shall provide to OHA by Administrative Notice, all of the documentation that Contractor relied upon to make its decisions, including those used to make the initial decision per OAR 410-141-3247 (9) (a) (b)(A)(B).
- (d) If a Member sends the Contested Case Hearing request to Contractor after Contractor has completed the initial plan appeal, Contractor shall:
- i. Date-stamp the hearing request with the date of receipt; and
 - ii. Submit the following required documentation to the Authority within two business days:
 - A. Copies of the Contested Case Hearing request, Notice of Adverse Benefit Determination, and Notice of Appeal Resolution; and
 - B. All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3245.

6. Contested Case Hearings

Contractor ~~grievance's~~ Grievance and ~~appeal system~~ Appeal System shall provide ~~its~~ Contractor's Members access to a ~~contested case hearing~~ Contested Case Hearing before OHA. Members must complete Contractor's ~~appeal~~ Appeal process prior to receiving a hearing with OHA. In ~~the~~ any case where a ~~CCO~~ Contractor fails to adhere to the notice or timing requirements; set forth in OAR 410-141-3225 through 410-141-3246, the ~~enrollee~~ Member is deemed to have exhausted the ~~CCO appeals~~ Contractor Appeals process and may initiate a Contested Case Hearing.

- ~~a.~~ If a Subcontractor or Participating Provider filed an appeal on behalf of Member as permitted by OAR 410-141-3245, the Subcontractor or Participating Provider must be allowed to request a Contested Case Hearing ~~requests must be filed by a~~ on behalf of Member with ~~Contractor or OHA, no later than 120 days from the date of the notice of Appeal resolution.~~ 's Grievance and Appeal System must provide for the following:
- ~~a.~~ b. Upon receipt of a request for a ~~contested~~ Contested Case Hearing, Contractor shall: ~~Date~~ date stamp the hearing request with the date of receipt; and immediately transmit the request to OHA with a copy of Contractor's ~~notice~~ Notice of Appeal Resolution ~~as described in this exhibit.~~
 - b. Contractor shall provide to OHA, upon request, a copy of the NOABD that was the subject of the Appeal that has proceeded to Contested Case Hearing.

- a. Contractor shall submit the required documentation described in OAR 410-141-3247 and 410-141-3245 to the OHA Hearings unit within two ~~business days~~(2) Business Days of ~~the~~Member's request for a Contested Case Hearing.
- b. Parties to the Contested Case Hearing include:
 - (1) The Member and the Representative;
 - (2) Contractor; and
 - (3) The legal representative of a deceased Member's estate.
- e. A ~~member~~Member who believes that taking the time for a standard resolution of a Contested Case Hearing could seriously jeopardize the ~~member~~Member's life ~~or~~, health, or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing, as described in OAR 410-141-3248.

7. Continuation of Benefits:

- a. A ~~member~~Member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount as previously authorized while an ~~appeal~~Appeal or ~~contested case hearing~~Contested Case Hearing is pending. As used in ~~this section~~Ex. I, Sect. 6, “timely” filing means filing on or before the later of the following:
 - (1) Within ten (10) days after the date of the ~~Notice of adverse benefit determination~~NOABD; or
 - (2) The intended effective date of the Action proposed in the ~~notice~~NOABD.
- b. The Contractor shall continue the Member's benefits if:
 - (1) The Member or Member's Representative timely files the Appeal or Contested Case Hearing request ~~timely~~;
 - (2) The Appeal or Contested Case Hearing request involves the termination, suspension, or reduction of ~~a~~ previously authorized services;
 - (3) ~~The Services were ordered by an~~An authorized Provider ordered the services;
 - (4) The period covered by the original authorization has not expired; and
 - (5) The Member timely files for continuation of benefits.
- c. **Duration of Continued Benefits**
 - (1) **Continuation of benefits pending ~~appeal~~Appeal resolution:**

If, at the Member's request, the Contractor continues or reinstates the Member's benefits while the Appeal is pending, pursuant to 42 CFR ~~438.402~~§438.420(c) the benefits must be continued until one of the following occurs:

 - (a) The Member withdraws the Appeal;
 - (b) The Contractor issues an Appeal Resolution; or
 - (c) The original authorization expires or the authorization service limits are met.
 - (2) **Continuation of benefits pending Contested Case Hearing resolution**

If, at the Member's request, the Contractor continues or reinstates the Member's benefits while the Contested Case Hearing is pending, pursuant to 42 CFR ~~438.402~~§438.420(c) the benefits must be continued until one of the following occurs:

- (a) The Member does not request a Contested Case Hearing within ten (10) days from when the Contractor mails the ~~notice~~Notice of Appeal ~~resolution~~Resolution letter
- (b) The Member withdraws ~~his or her request~~their Request for ~~hearing~~Contested Case Hearing;
- (c) A final Contested Case Hearing decision adverse to the Member is issued; or
- (d) The original authorization expires or authorization service limits are met.

d. **Member responsibilities for services furnished while the ~~appeal~~Appeal or ~~contested-case~~Contested Case hearing is pending:**

If the ~~Final Resolution~~final resolution of the Appeal or Contested Case Hearing ~~is adverse to the Member, that is,~~ upholds the Contractor's Adverse Benefit Determination, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal or hearing was pending ~~under~~pursuant to 42 CFR §431.230 (b), to the extent that they were furnished solely because of the requirements of Ex. I, Sec. 6 of this ~~section~~Contract.

8. Implementation of Reversed Appeal Resolution

a. Services not furnished while an ~~appeal~~Appeal is pending

If the Contractor or Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal or ~~hearing~~Contested Case Hearing was pending, the Contractor shall authorize or provide; the disputed services promptly; and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date ~~it~~Contractor receives the ~~notice~~decision reversing the ~~determination~~Adverse Benefit Determination.

b. Services furnished while an ~~appeal~~Appeal is pending

If the Contractor or Administrative Law Judge reverses a decision to deny authorization of services, and the ~~Member received the~~ disputed services were furnished while the Appeal or ~~hearing~~Contested Case Hearing was pending, the Contractor shall pay for the services.

9. Final Order on Contested Case Hearings

OHA will resolve ~~the case~~Contested Case Hearing ordinarily within ninety (90) days from the date the Contractor receives the ~~member~~Member's request for ~~appeal~~Appeal. This does not include the number of days the ~~member~~Member took to subsequently file a ~~contested case~~Contested Case hearing request. The final order is the final decision of OHA.

10. Record Keeping and Quality Improvement

a. Contractor shall document and maintain a record of all Member Grievances and Appeals in accordance with OAR 410-141-3245, 410-141-3255 and 42 CFR §438.416. Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA ~~monitoring~~Monitoring and oversight.

b. Contractor shall maintain record, in a central location accessible to OHA and ~~CMS~~available upon request to CMS, for each ~~grievance~~Grievance and ~~appeal~~Appeal. The record shall include, at a minimum:

A general description of the reason for the ~~appeal~~Appeal or ~~grievance~~Grievance and the supporting reasoning for its resolution;

- (1) The ~~members~~Members name; and ID;
- (2) The date Contractor received the ~~member~~Grievance or ~~members representative, or provider~~Appeal filed by the ~~grievance~~Member, Subcontractor, or ~~appeal~~Provider;
- (3) ~~Notice of Adverse Benefit Determination;~~The NOABD;
- (4) If filed in writing, the Appeal or Grievance;
- (5) If ~~an oral filing was received~~filed orally, documentation that the Grievance or Appeal was received orally;

- (6) Records of the review or investigation at each level of the ~~appeal~~Appeal, ~~grievance~~Grievance, or ~~hearing~~Contested Case Hearing;
- (7) Notice of resolution of the Grievance or Appeal, including dates ~~for~~of resolution at each level; ~~and~~
- (8) ~~Resolution including all written decisions and copies~~Copies of correspondence with the ~~member~~Member and all evidence, testimony, or additional documentation provided by the ~~member~~Member, the ~~member~~Member's ~~representative~~Representative, or the ~~member~~Member's ~~provider~~Provider as part of the ~~appeal~~Grievance, Appeal, or Contested Case Hearing process; and
- (9) All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or ~~hearing~~Contested Case Hearing.

11. OHA Review and Approval of Grievance and Appeal System, Policies and Procedures, and Member Notice Templates

Prior to use and no later than November 1, 2019, Contractor shall provide to OHA for review and approval, via Administrative Notice, Contractor's Grievance and Appeal System, all policies and procedures related thereto, Member notice templates (which shall include, but not limited to (i) a Grievance resolution notice, (ii) an NOABD, and (iii) Notice of Appeal Resolution), and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System. Contractor's Grievance and Appeal System shall not be made available for use, adopted, implemented, nor distributed to Members or Participating Providers prior to receipt of OHA's Administrative Notice of approval.

~~a. e.~~ The ~~contractor shall provide to OHA Contract Administration Unit~~ following apply to the review and approval or disapproval of Contractor's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System:

- (1) Contractor shall annually review, and if necessary, update its Grievance and Appeal System, policies and procedures related thereto, and Member notice templates. Contractor shall provide OHA's Contract Administrator, via Administrative Notice, with Contractor's Grievance and Appeal System for review and approval by January 31 of Contract Years two through five regardless of whether Contractor proposes updates to its Grievance and Appeal System, policies and procedures related thereto, or Member notice templates.
- (2) At the time Contractor makes any changes to the approved Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, Contractor shall provide OHA's Contract Administrator with Administrative Notice that identifies proposed changes with particularity and when applicable includes the revised Grievance and Appeal Handbook or any other documents relating thereto.
- (3) Within five (5) Business Days after the request of OHA, including but not limited to requests in connection with or following a quarterly review pursuant to this Ex. I, Sec. 10, Para. b, or to requests in connection with or following a Contested Case Hearing, Contractor shall provide OHA, via Administrative Notice, Contractor's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, or any

other documents to be provided to Members regarding Contractor's Grievance and Appeal System, to OHA for compliance review. Without limiting any other provision in this Contract, in the event OHA, CMS, or EQRO determine Contractor's Grievance and Appeal System Member template notices do not comply with Applicable Laws, or with the terms and conditions of this Contract, Contractor must revise such Member template notices within thirty (30) days of notification by OHA, CMS, or EQRO of non-compliance and submit them to OHA, via Administrative Notice, for review and approval or disapproval.

- (4) Contractor must obtain OHA approval of Member materials included in Contractor's Grievance and Appeal system, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System prior to implementing and providing such materials to Members. . .
- (5) Within thirty (30) days of receipt of Contractor's Grievance and Appeal System or changes to Contractor's approved Grievance and Appeal System, policies and procedures related thereto, Member notice templates, or any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, OHA will provide Contractor's Contract Administrator with Administrative Notice of OHA's approval or disapproval of Contractor's Grievance and Appeal System. OHA may disapprove of all or part of Contractor's Grievance and Appeal System based on any failure to comply with this Contract and any other the Applicable Laws. In the event OHA does not approve Contractor's Grievance and Appeal System, Contractor must follow the process set forth in Sec. 5, Ex. D to this Contract.
- (6) Upon approval, Contractor's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, must be included in Contractor's Member Handbook and in Contractor's Participating Provider Handbook

b. Within forty-five (45) days following after the end of each calendar quarter, Contractor shall provide to OHA, via Administrative Notice, the following documentation, ~~at a minimum~~ (which shall include any and all documentation required to be held and maintained by Contractor's Subcontractors):

- (1) A Grievance and Appeal Log in a format provided by OHA and available at <http://www.oregon.gov/OHA/healthplan/pages/CCO-Contract-Forms.aspx> on the CCO Contract Forms Website;
- (2) Samples of ~~Notices of Adverse Benefit Determination~~NOABD and corresponding ~~prior authorization~~Prior Authorization documentation. Contractor's Prior Authorization ~~Record~~template shall include, at a minimum: date of the request for the service, the ~~diagnoses~~diagnosis codes, including but not limited to medical, dental, behavioral, and transportation billing codes, submitted, the CPT or ~~HCPC~~HCPCS (treatment) codes being requested, and any comorbid diagnosis codes that the ~~provider~~Provider may list on the authorization request. OHA will randomly select samples from Contractor's Grievance and Appeal log for the corresponding quarter— for review. The sample size ~~is twenty~~per quarter is a minimum of twenty samples and a maximum of samples numbering up to ten percent (10%) of the number of NOABDs issued during the quarter. Contractor shall

submit records for the samples selected by OHA in the manner directed by OHA in its request no later than fourteen (14) days following receipt of OHA's request.;

(3) All ~~Adverse-Benefit Determination Notices for ABA~~NOABDs for Applied Behavioral Analysis and Hepatitis C for the previous calendar year; and

(4) Any other related documentation requested by OHA.

~~c. d. The~~Within forty-five (45) days after the end of each calendar quarter, Contractor shall submit provide its Grievance System ~~Narrative Report, to OHA via Administrative Notice. Such~~ Grievance System Report shall be in a format provided by OHA ~~and which is~~ available at ~~http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx, The on the CCO~~ Contracts Forms Website. Contractor shall use data collected from ~~monitoring of its grievance~~its own and its Subcontractors' Monitoring of Contractor's Grievance and Appeal ~~system to analyze its~~ System., including ~~all grievance~~the Grievance and ~~appeals~~Appeal data reported by ~~the CCO~~Contractor and Subcontractors in ~~the~~their Grievance and Appeal ~~Log. The logs to analyze such system. Contractor shall demonstrate how the CCO Contractor uses the data it has collected by the CCO for itself and its subcontractors, Subcontractors to maintain an effective process for monitoring Monitoring, evaluating, and improving the access, quality and appropriateness of services provided to members Members. -~~

~~e. The Contractor shall submit to OHA Contract Administration Unit annually, on January 31st, Contractor Grievance and Appeal system policies and procedures. Documentation shall address comprehensive System maintained by the CCO to comply with OAR 410-141-3225 through 410-141-3255.~~

~~d. f. The~~ Contractor shall promptly comply with all Grievance and ~~appeal~~Appeal records requests from ~~OHA, CMS, EQRO or other external auditors. Contractor shall submit, in accordance with such request,~~ records to OHA's Contract ~~Administration Unit~~Administrator, no later than fourteen (14) days following Contractor's receipt of a request, except where request is related to a Contested Case Hearing ~~where, in which case~~ Contractor shall submit required documentation within twenty-four (24) hours for an expedited hearing and two (2) days for a ~~standard non-expedited~~ hearing. Contractor is ~~accountable~~responsible for ~~collection~~collecting and ~~submission of grievance~~submitting the Grievance and ~~appeal~~Appeal records maintained in part, or in full, by Subcontractors. ~~g. Contractor shall monitor revise Grievance and Appeal Systems or Guidebooks (or both), within thirty (30) days of notification by CMS or EQRO of non-compliance with this Contract, and applicable federal, and State laws. If OHA does not approve of Contractor's Grievance and Appeal System or Guidebooks, Contractor must follow the process set forth in Sec. 5, Ex. D to this Contract.~~

~~e. Contractor shall review for completeness and accuracy the data collected from its grievance system by the CCO the Grievance and Appeal Systems of Contractor and its Subcontractors, internally on a monthly basis for completeness and accuracy, and provide the results of such review to OHA, federal, state, and OHA contracted auditors upon request.~~

~~f. h. The~~ If Contractor ~~shall submit records of monitoring of Grievance and Appeal system~~ has delegated, in part or in full, Monitoring of any Grievance and Appeal System to ~~its~~ Subcontractors or Participating Providers, Contractor shall submit records of such Monitoring to OHA, federal, state, and OHA contracted auditors, upon request. ~~Contractor~~Such Subcontractor or Participating Provider records shall provide evidence of compliance, as required under 42 CFR §438.230, with provisions in this Contract ~~for Subcontractors and 42 CFR 438.230.~~

~~Records~~ under OAR 410-141-3225 through 410-141-3255, and 42 CFR §§438.400 through 438.424 and this Exhibit I. The records submitted under Ex. I, Sec. 10, Para. f. of this Contract shall include any Corrective Actions initiated by Contractor as a result of Subcontractor ~~monitoring~~ or Participating Provider Monitoring, up to and including termination of Subcontractor ~~or Participating Provider~~. Contractor shall submit all records ~~to OHA Contract Administration Unit~~ requested under Ex. I, Sec. 10, Para. f. of this Contract to OHA, via Administrative Notice, no later than ~~14 calendar~~fourteen (14) days following receipt of the request or in a timeframe established by the requesting ~~party~~entity.

- ~~i. Contractor shall revise grievance and appeal system policies and procedures within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract grievance and appeal system requirements. Contractor shall cause Subcontractors delegated Work of grievance and appeal system to revise grievance and appeal system policies and procedures within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract grievance and appeal system requirements. Contractor shall submit revised materials to OHA for review and approval.~~
- ~~j. Contractor shall revise grievance and appeal system member Notices within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract requirements. Contractor shall cause Subcontractors to revise grievance and appeal system member Notices within 30 days of notification by OHA, CMS or EQRO of non-compliance with Federal, State or Contract grievance and appeal system requirements. Contractor shall submit revised materials to OHA for review and approval.~~
- ~~k. OHA will monitor Contractor compliance and provide Contractor notice of non-compliance, as needed. Contractor is accountable for correcting any and all aspects of its grievance and appeal system identified as non-compliant, whether Work is performed by Contractor or delegated by Contractor to Subcontractors. OHA may proceed with placing Contractor on a work plan or Corrective Action up to and including sanctions and termination of Contractor managed care contact. Contractor shall provide evidence of correction to OHA Contract Administration unit within 30 days of receipt of notice.~~

[Remainder of page intentionally left blank]

Exhibit J—

Health Information Technology

1. Health Information Technology Requirements

- a. Contractor shall maintain a ~~health information system~~Health Information System that: ~~1~~i) meets the requirements of this Contract; ~~2~~ii) meets the requirements of 42 CFR § 438.242 and section 1903(r)(1)(F) of PPACA; and 3) ~~will collect, analyze, integrate~~collects, analyzes, integrates and ~~report~~reports data that can provide information on areas including but not limited to:
- (1) Names and phone numbers of the Member's Primary Care Physician or clinic;
 - (2) Client Process Monitoring System Forms data. OHA is closing the CPMS system and replacing it with the Measures and Outcome Tracking System (MOTS).
 - (3) Copies of completed Request for LTPC ~~Determination Forms~~determination forms;
 - (4) Evidence that the Member has been informed of rights and responsibilities;
 - (5) Grievance, Appeal and ~~hearing~~Contested Case Hearing records;
 - (6) Utilization of services;
 - (7) Disenrollment for other than loss of Medicaid eligibility;
 - (8) Covered Services provided to Members, through ~~encounter data~~Encounter Data system or other documentation system; and
 - ~~(9) Member characteristics, including but not limited to race, ethnicity and preferred language in accordance with OHA and DHS standards.~~
- ~~b. Contractor shall collect data at a minimum on:~~
- ~~(9)~~ (4) Member demographics such that such information collected includes, at a minimum, those characteristics and required to be collected under Sec. 6 of Ex. K to this Contract.
 - (10) Those Provider characteristics ~~as~~ required ~~into~~ to be collected under Exhibit G to this Contract;
 - (11) ~~(2)~~ Member Enrollment; and
 - (12) ~~(3)~~ Services provided to Members for pharmacy services, and encounter
 - (13) All data required to be reported in connection with Encounter Data reporting.
- b. ~~e.~~ 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~~OARs 410-120-1280-~~and OAR, 410-141-3420, and 410-141-3430~~ by:
- (1) Verifying accuracy and timeliness of reported data;
 - (2) Screening data for completeness, logic and consistency;
 - (3) Submitting the certification ~~contained~~identified in Exhibit B, Part 8, ~~Section 7;~~
 - (4) Collecting service information in standardized formats in accordance with OHA Electronic Data Transmission (~~EDT~~) procedures in OAR Chapter 943 Division 120; ~~and~~

- (5) ~~Confirming~~Identifies any fees payable by Members, if any, as required under Member's responsibility for its portion of payment as stated in 42 CFR §438.10; and
- (6) 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~~Contractor, in accordance with 42 CFR §455.20 and 42 CFR §433.116 (e) and (f) contacted Members to confirm that billed services were provided. Such verification process must include, without limitation:
- (a) Providing ~~a~~notice, within forty-five (45) days of the payment of a claim, to all or a sample group of the Members who received services;
- (b) The notice must, based on information from the Contractor's claims payment system, specify request verification of, at a minimum, all of the following:
- i. ~~(i)~~ The services furnished;
 - ii. ~~(ii)~~ The name of the Provider furnishing the services;
 - iii. ~~(iii)~~ The date on which the services were furnished; and
 - iv. ~~(iv)~~ The amount of the payment made by the Member, if any, for the services; and
- (c) The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS.
- c. ~~d.~~In accordance with 42 CFR §438.242, Contractor shall make all collected and reported data available upon request to OHA and CMS (as specified in 42 CFR §438.242) or its designees, or both OHA and its designees.
- ~~e.~~ ~~Contractor shall report on proportion of contracted physical, behavioral and oral health providers adopting EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR; see https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition); proportion of contracted physical, behavioral and oral health providers who have access to HIE and proportion using HIE for care coordination; and proportion of contracted physical, behavioral and oral health providers who have access to, and proportion using, hospital event notifications.~~

2. Health Information Technology (HIT) Roadmap

- a. Contractor shall draft and maintain an OHA-approved HIT Roadmap. The HIT Roadmap must contain the information ~~defined~~identified in the RFA, and ~~inclusive~~include its plans setting forth all of Contractor's the activities, milestones, and timelines required to carry be carried out ~~Section/Items (f) (k) below. In its~~under the HIT Roadmap, as set forth below of this Para. (a) of this Sec. 2, Ex. J and achieve compliance with OAR 410-141-3180. Contractor shall ~~describe~~also include in its HIT Roadmap descriptions of how it ~~is using~~uses HIT to achieve desired outcomes. Contractor shall explain where it is implementing its own HIT systems and where it is leveraging collaborative HIT efforts, such as regional or statewide initiatives. In the event OHA does not approve its HIT Roadmap, Contractor shall follow the process set forth in Sec. 5, Ex. D. Based on the foregoing, Contractor's HIT Roadmap shall:
- ~~b.~~ ~~Contractor shall provide an annual HIT Roadmap update for OHA review and approval.~~

- ~~(1) The annual HIT Roadmap update must clearly identify any changes to prior approved HIT Roadmap.~~
- ~~(2) The annual HIT Roadmap update must include Contractor attestation to progress made on their HIT Roadmap and provide supporting information on progress made. OHA may request further information to support attestations.~~
- ~~(3) As part of the annual HIT Roadmap update, Contractor shall participate in an annual interview. OHA may also request further detail and that discussion of the annual HIT Roadmap update be part of the annual VBP interview.~~
- ~~(4) In the event that Contractor does not engage with the annual HIT Roadmap update process or does not achieve an approved updated HIT Roadmap via that process, OHA may offer technical assistance and reserves the right to require corrective action or other consequences including remedies authorized under this contract (See Exhibit D Section 9).~~
- ~~e. Contractor shall comply with its HIT Roadmap. In the event that Contractor does not comply with an approved HIT Roadmap, OHA may offer technical assistance and reserves the right to require corrective action or other consequences including remedies authorized under this contract (See Exhibit D Section 9).~~
- ~~d. Contractor shall participate as a member in good standing of the HIT Commons, as follows:~~
- ~~(1) Contractor shall maintain an active, signed HIT Commons MOU. Describe how Contractor will facilitate EHR adoption and use for its Provider Network, including physical, Behavioral, and oral Health Providers;~~
 - ~~(2) Contractor shall adhere to the terms of the HIT Commons MOU. Set target rates for increasing EHR adoption among its contracted physical, Behavioral, and Oral Health Providers and actively work with such Providers to remove barriers to EHR adoption;~~
 - ~~(3) Describe how Contractor will support access to HIE that enables sharing patient information for Care Coordination for its contracted physical, Behavioral, and Oral Health Providers;~~
 - ~~(4) Describe how Contractor will ensure access to timely Hospital event notifications for its contracted physical, Behavioral, and Oral Health Providers;~~
 - ~~(5) Describe how Contractor will implement and use (or just use) Hospital event notifications within Contractor's organization, for example, to support Care Coordination and/or population health efforts;~~
 - ~~(6) Set target rates for increasing access to HIE for care coordination among its contracted physical, Behavioral, and Oral Health Providers and actively work with such Providers to remove barriers to HIE adoption;~~
 - ~~(7) Set target rates for increasing access to Hospital event notifications among its contracted physical, Behavioral, and Oral Health Providers and actively work with such Providers to remove barriers to adoption of Hospital event notifications; and~~
 - ~~(8) Describe how Contractor will implement and maintain necessary information technology infrastructure necessary to support VBP contract arrangement permitted under this Contract which includes, without limitation using HIT for;~~

- (a) Administering VBP arrangements;
 - (b) Supporting contracted Providers with VBP arrangements with actionable data, attribution, and information on performance; and
 - (c) Population health management.
- b. ~~(3)~~ Contractor shall ~~pay~~ participate as a Member in good standing of the HIT Commons. In doing so, Contract shall do all of the following:
- (1) Maintain an active, signed HIT Commons MOU;
 - (2) Adhere to the terms of the HIT Commons MOU;
 - (3) Pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU; and
 - (4) ~~Contractor shall serve~~ Serve, if elected, on the HIT Commons governance board or one of its committees.
- c. ~~e.~~ Contractor's designated representative shall participate in OHA's HIT Advisory Group (HITAG), at least once annually.
- ~~f.~~ Contractor shall support EHR adoption for its contracted physical, behavioral, and oral health providers.
- ~~g.~~ Contractor shall support access to health information exchange that enables sharing patient information for care coordination for its contracted physical, behavioral, and oral health providers.
- ~~h.~~ Contractor shall ensure access to timely hospital event notifications for its contracted physical, behavioral, and oral health providers.
- ~~i.~~ Contractor shall use hospital event notifications within the CCO, for example, to support care coordination and/or population health efforts.
- ~~j.~~ Contractor shall use HIT to administer VBP arrangements; support contracted providers with VBP arrangements with actionable data, attribution, and information on performance; and use HIT for population health management.
- ~~k.~~ Contractor shall report annually to OHA on its activities in this section. Reports shall be submitted for review and approval to OHA. OHA may ask Contractor's contracted providers for information to support the monitoring process. If not otherwise specified, reporting format, definitions, and deadlines will be determined during Readiness Review. Required reporting elements are as follows:
- d. For Contract Years two through five, Contractor shall draft an annual Updated HIT Roadmap. Such Updated Roadmap shall include a report detailing the progress made on the HIT Roadmap from the previous Contract Year. The Updated HIT Roadmap shall be provided to OHA for review and approval via Administrative Notice on or before March 15 of Contract Years two through five. The Updated HIT Roadmap for Contract Years two through five must clearly identify any new information, activities, milestones, timelines which were not included in the HIT Roadmap for the previous Contract Year. The Updated Hit Roadmap shall include, without limitation:

- (1) Attestations by Contractor ~~shall attest~~ that it:
 - (a) ~~has~~Has an active, signed HIT Commons MOU.
 - (b) ~~adheres~~Adheres to the terms of the HIT Commons MOU.
 - (c) ~~has~~Has paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
 - (d) ~~serves~~Served, if elected, on the HIT Commons governance board or one of its committees.
 - (e) ~~participates~~Participated in OHA's HITAG, at least ~~annually~~once during the previous Contract year.
- (2) ~~Contractor shall report~~Identify the EHR(s) vendor/product in use by each of its contracted physical, ~~behavioral~~Behavioral, and ~~oral health providers~~Oral Health Providers.
- (3) ~~Contractor shall report~~Describe the progress ~~on~~made towards meeting EHR adoption targets ~~via the Performance Expectations reporting described in Exhibit M.~~
- ~~(4) Contractor shall report the HIE tool(s) in use by each of its contracted, including, without limitation, the proportion of~~ physical, behavioral, and oral health providers Oral Health Providers adopting Electronic Health Records including those with any EHRs, Certified EHRs, and 2015 Certified EHRs. See: <https://chpl.healthit.gov/>
and
<https://www.healthit.gov/topic/certification-ehrs/2015-edition>
- (4) Identify the HIE tool(s) used by each of its physical, Behavioral, and Oral Health Providers for care coordination.
- (5) ~~Contractor shall report progress on HIE access targets via the Performance Expectations reporting described in Exhibit M.~~Identify the tool(s) used by each of its physical, Behavioral, and Oral Health Providers for Hospital event notifications;
- (6) Describe the progress made towards achieving HIE access targets for both care coordination and identify both (i) the proportion of those physical, behavioral and Oral Health Providers who have access to HIE for Care Coordination and (ii) the proportion using HIE for Care Coordination
- (7) Describe the progress made towards achieving access targets for Hospital event notifications and identify both (i) the proportion of physical, behavioral and Oral Health Providers who have access to Hospital event notifications, and (ii) proportion using Hospital event notifications.
- (8) ~~(6) Contractor shall report on~~Describe how Contractor used HIT to administer its VBP arrangements in place at the start of the year and provide supporting detail about implementation approach.
- (9) ~~(7) Report on how~~ Contractor ~~shall report on how it~~ used HIT to support ~~contracted providers~~Providers so they can effectively participate in VBP arrangements, including details ~~on~~regarding:

- (a) How Contractor provided ~~contracted providers~~Providers with VBP arrangements with timely (e.g. at least quarterly) information on measures used in the VBP arrangements applicable to the contracted ~~providers~~Providers;
 - (b) How Contractor provided ~~contracted providers~~Providers with VBP arrangements with accurate and consistent information on patient attribution;
 - (c) How Contractor identified, for ~~contracted providers~~Providers with VBP arrangements, (or provided contracted ~~providers~~Providers with VBP arrangements with the information needed for those ~~providers~~Providers to identify) specific patients who needed intervention throughout the year so they could take action before the year-end;
 - (d) How Contractor provided any other actionable data to ~~contracted providers~~Providers to support ~~providers~~Providers' participation in VBP arrangements, including data on risk stratification and ~~member~~Member characteristics that can inform the targeting of interventions to improve outcomes;
 - (e) ~~Percentage~~The percentage of ~~contracted providers~~Providers with VBP arrangements at the start of the year who had access to these above data;
- (10) ~~(8)~~ Contractor shall report on how it used HIT for population health management, including:
- (a) ~~Report on~~Details relating to Contractor's capability to risk stratify and identify and report on ~~member~~Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes; and
 - (b) For Years 2-5, Contractor shall report on provision of risk stratification and ~~member~~Member characteristics to contracted ~~providers~~Providers with VBP arrangements for the population(s) included in the arrangement(s).
- e. Contractor shall also identify any adjustments that it made to its Annual HIT Roadmap for the subsequent Contract Year based on the reporting made on the topics identified in SubParas. (1)-(9) above of this Para. d, Sec. 2, Ex. JOHA shall have the right to obtain directly from Contractor's Providers information that supports Contractor's HIT Roadmap activities and progress and other information included in Contractor's Updated HIT Roadmap.
- f. Contractor shall participate in an interview with OHA relating to its Updated HIT Roadmap as requested by OHA from time to time. OHA shall have the right to request, and Contractor shall be required to provide, additional details regarding its HIT Roadmap.

[Remainder of page intentionally left blank]

Exhibit K -Social Determinants of Health and Equity

1. **Community Advisory Council.** To ensure that the health care needs of all Members of the Community within Contractor's Service Area are being addressed, Contractor shall, in accordance with ORS 414.627, establish a Community Advisory Council that will advise Contractor on such matters.
2. **Community Advisory Council Membership**
 - a. Contractor shall convene a CAC Selection Committee that will be responsible for selecting the members of the CAC. The CAC Selection Committee must be comprised of, in equal numbers: (i) persons who sit on Contractor's governing board, and (ii) persons who are representatives of each county within Contractor's Service Area. The CAC Selection Committee shall ensure the CAC:
 - (1) Includes representatives from the community, including, but not limited to, Consumer Representatives, and representatives of each county government within Contractor's Service Area. Consumer Representatives must constitute a majority of the CAC; and
 - (2) Is representative of the diversity of populations within Contractor's Service Area, with a specific emphasis on persons who are representative of populations that experience health disparities;
 - b. Contractor's CAC Selection Committee shall select all of its CAC members promptly but in no event later than March 31, 2020.
 - c. In the event a CAC member resigns, is asked to resign, or is otherwise unable to serve on the CAC, Contractor shall promptly replace the empty seat within two months of the CAC seat becoming open.
 - d. Contractor must designate a CAC Coordinator and maintain a written job description detailing the CAC Coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including: (i) ensuring committee meetings are scheduled and committee agendas are developed; and (ii) maintaining committee membership (including outreach, recruitment, and onboarding of new members) that is adequate to carry out the duties of the CAC ; (iii) actively facilitating communication and connection between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC; (iv) ensuring facilities, materials, and other components necessary to conduct a CAC meeting are accessible by Member and other attendees who have a disability, limited English language proficiency, and diverse cultural and ethnic backgrounds, to facilitate inclusion; (v) ensuring compliance with all CAC reporting and public posting requirements. The CAC Coordinator may be an employee of Contractor or a Subcontractor of Contractor. The CAC Coordinator must not be a member of the CAC or a Member Enrolled with Contractor.
 - e. Additional information and guidance on CACs are found at the following website: <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx>
 - f. Notwithstanding the deadlines set forth in Paras. b and c above of this Sec. 2, Ex. K, in the event Contractor has not previously entered into a contract with OHA to provide the same or similar services required to be provided under this Contract, or this Contract requires Contractor to provide services in Service Area not previously served by Contractor, Contractor may request from OHA an extension of time of up to three months to complete its selection of CAC members. Any Contractor may request from OHA an extension of time of up to one month to

complete its replacement of CAC members. OHA shall have the right to disapprove a request for extension of time in its reasonable discretion. Requests for extensions of time must be via Administrative Notice.

3. Community Advisory Council Meetings.

a. The CAC meetings are not subject Oregon’s Public Meetings laws set forth in ORS 192.610 – 192.690. However, Contractor may choose to make the regularly scheduled CAC meetings open to the public. If the regularly scheduled 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, Contractor shall hold semiannual meetings that:

- (1) Are open to the public and attended by the members of the CAC;
- (2) Report on the activities of the Contractor and the CAC;
- (3) Provide written reports on the activities of the Contractor;
- (4) Provide the opportunity for the public to provide written or oral comments; and

b. Contractor must post on its website contact information for, at a minimum,

- (1) The CAC Chairperson; and
- (2) A Member of the CAC or an employee of and designated by Contractor.

c. The CAC shall:

- (1) Hold its first regular meeting promptly after all of the CAC members have been selected by the CAC Selection Committee, but in no event shall the first regular meeting be held later than June 30, 2020. At all times thereafter, the CAC shall meet no less than once every three months Notwithstanding the June 30, 2020 deadline, in the event Contractor has not been a party to a Predecessor Agreement , or this Contract requires Contractor to provide services in Service Area not previously served by Contractor, Contractor may request from OHA up to a three month extension to hold its first regular meeting. Any such request shall be made on June 1, 2020 via Administrative Notice. OHA shall have the right to disapprove a request for extension of time in its reasonable discretion..
- (2) Shall draft written reports of each of its meetings and the associated discussions. All reports must be posted on Contractor’s website and, as appropriate to keep the Communities within Contractor’s Service Areas informed of the CAC’s activities, on other websites. The CAC, the Contractor’s governing body, a designee of the CAC, or a designee of Contractor’s governing body has the discretion to determine whether public comments received at meetings open to the public will be included in the reports posted on Contractor’s website and, if so, which comments are appropriate for posting.

4. Duties of the CAC

a. The CAC shall carry out the duties required under ORS 414.627(2) and as set forth in this Contract. Such duties include, without limitation:

- (1) Identifying and advocating for preventive care practices to be utilized by the Contractor;
- (2) Directing, tracking, and reviewing Contractor Health-Related Services/Community Benefit Initiatives required to be undertaken in accordance with OAR 41-141-3150 and as set forth in Sec. 9 below of this Ex. K.

- (3) Overseeing Contractor's development and drafting of Community Health Assessment ;
- (4) Adopting a Community Health Improvement Plan which shall be based on the Community Health Assessment and serve as Contractor's strategic plan for addressing health disparities and meeting health needs for all of Contractor's Members residing in the Communities within Contractor's Service Area(s); and
- (5) Publishing an Annual CHP Progress Report.

5. Contractor's Annual CAC Demographic Report.

- a. To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area Contractor shall complete and submit to OHA annually an Annual CAC Member Demographic Report. . The Annual CAC Demographic Report shall include descriptions of all of the following:
 - (1) The demographic composition of CAC membership
 - (2) How Contractor defines the demographics and diversity of its Members within Contractor's Service Areas;
 - (3) The data sources relied upon by Contractor to validate its CAC membership aligns with Contractor's Member demographics;
 - (4) Whether and how Contractor's CAC total membership is in alignment with Contractor's CHP priorities, the number of Consumer Representatives sitting on the CAC comprise a majority of the CAC's total membership, what number of Consumer Representatives are OHP Members (as opposed to the parent, guardian, or caregiver of an OHP Member), and what percentage of the total CAC membership are Consumer Representatives;
 - (5) The intent and justification for CAC composition;
 - (6) Barriers to and challenges in meeting or increasing alignment between CAC membership with the demographics of the Members within Contractor's Service Area,
 - (7) Ongoing and updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area
 - (8) A description of the CAC's ongoing role in decision-making about Health-Related Services Community Benefit Initiatives, SDOH-E spending decisions, and other Community-based initiatives; and
 - (9) Contractor's organizational chart. The organizational chart shall indicate:
 - (a) The number of persons and the names of the persons who sit on Contractors' governing board who also sit on Contractor's CAC;
 - (b) A narrative that describes relationship between the CAC and Contractor's governing board, any other Contractor committees, and Contractor's Subcontractors;
 - (c) How information flows between Contractor and CAC; and
 - (d) How all of the demographic, comparative, and means of communication provided in response to Sub.Paras. (1)- (10) of this Para.a, Ex. K, compare in relation to, as applicable, the tribes or tribal advisory committee in Contractor's Service Area. .

- b. Contractor must also provide the same information required to be submitted under Sub. Para. (9) of Para. a above of this Section 5, of Ex. K to OHA in the Subcontractors and Delegated Entities Report located on the CCO Contract Forms Website. Contractor shall also submit a graphic that illustrates the same information. Both of the foregoing documents shall be provided to OHA annually at the same time Contractor's CAC Demographic Report is provided to OHA.
- c. Contractor's Annual CAC Demographic Report shall be provided, via Administrative Notice by no later than June 30th of each Contract Year beginning with June 30, 2021.
- d. OHA will post Contractor's Annual CAC Demographic Report on OHA's website, with the personally identifiable demographic information of CAC membership redacted.

6. Community Health Assessment

- a. Contractor, through its CAC, shall draft a Community Health Assessment in accordance with OAR 410-141-3145 and in compliance with ORS 414.627. The purpose of a CHA is to assess the health status and needs of the population within Contractor's Service Area and then use the CHA to create and implement a Community Health Improvement Plan.
- b. To the extent Contractor shares all or part of a Service Area, Contractor must develop a shared CHA with all of the following organizations and entities: local public health authorities, Hospitals, other CCOs, and, if a federally recognized tribe has already developed or will develop their own CHA or CHP, Contractor must invite the tribe to participate in the shared CHA and CHP. These entities will be referred to as the Collaborative CHA/CHP Partners. This collaboration shall be documented in the CHA and CHP documents, inclusive of CHP progress reports.
- c. Contractor, in creating and maintaining its shared CHA with the Collaborative CHA/CHP Partners, must do all of the following:
 - (1) Meaningfully and systematically engage representatives of local governments, local Tribal Organizations, community partners and stakeholders, and critical populations to assess the Community health needs of Contractor's Service Area.
 - (a) Contractor may utilize the OHA Office of Equity & Inclusion's community engagement checklist to support meaningful engagement throughout the CHA and CHP process, which is located at the following URL:
https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf
 - (b) The entities within the Contractor's Service Areas that must be engaged in the creation of the CHA must include, without limitation:
 - i. County and city government representatives,
 - ii. Federally recognized tribes (if not already collaborating on a shared CHA),
 - iii. SDOH-E Partners
 - iv. Local mental health authorities and community mental health programs,
 - v. Physical, behavioral, and Oral Health care providers
 - vi. Indian Health Care Providers,
 - vii. Traditional Health Workers,

- viii. Culturally specific organizations, including Reginal Health Equity Coalitions.
- (c) Representatives from populations who are experiencing health and health care disparities.
- (2) Act with transparency; and
- (3) Utilize guidance documents and other resources provided by OHA to plan, develop, and draft its CHA. Such guidance documents and other resources are found at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/chachp-technical-assistance.aspx?Paged=TRUE&PagedPrev=TRUE&p_Modified=20180223%2017%3a40%3a50&p_ID=56&PageFirstRow=31&&View={59B80799-10C3-491E-98AB-96D7FC0F8C8F}
- d. Contractor's shared CHA must comply, at a minimum, all of the following requirements:
- (1) Identify the demographics of all of the Communities served within Contractor's Service Area, including race, ethnicity, languages spoken, disabilities, age, gender, sexual orientation, and other applicable identifying factors;
- (2) Identify and describe the health status and issues of all the Communities within Contractor's Service Area;
- (3) Identify the health disparities among all of the Communities, including those defined by race, ethnicity, languages spoken, disabilities, age, gender, sexual orientation, and other factors within Contractor's Service Area;
- (4) Determine and identify factors that contribute to health disparities among, all of the Communities served within Contractor's Service Area;
- (5) Include findings on health indicators, including the leading causes of chronic disease, injury and death within Contractor's Service Area;
- (6) Include findings on SDOH indicators across the four key SDOH domains (economic stability, education, neighborhood and built environment, social and community health).
- (7) Identify assets and resources that can be utilized to improve the health of the all of the Communities served within Contractor's Service Area with an emphasis on determining the current status of:
- (a) Access to primary prevention resources;
- (b) Disproportionate, unmet, health-related needs;
- (c) Community capacity to improve community health;
- (d) Systems of seamless Continuum of Care; and
- (e) Systems or programs of collaborative governance of community benefit;
- (8) Identify the existence of programs that promote the health and treatment of children and adolescents within Contractor's Service Area, including any treatment prevention and Early Intervention programs, and analyze the sufficiency and effectiveness of any such programs;
- (9) Identify and analyze whether existing funding sources are sufficient to address the health needs of children and adolescents within Contractor's Service Area; and

- (10) An evaluation of existing school-based health resources, including School Based Health Center, school nurses, and electronic medical records systems, and an analysis of whether such systems are capable of meeting the specific pediatric and adolescent health care needs within Contractor's Service Area.
- (11) Identify areas of improvement; and
- (12) Document the persons, organizations, and entities with whom Contractor collaborated in creating the CHA, which persons, organizations, and entities must include those identified in Paras. b and c above of this Sec. 6, Ex. K.
- e. Contractor's CHA may, but is not required to include, the following:
- (1) Consider any findings on the health needs of the Communities served within Contractor's Service Area which have been found through other Community health assessments or similar assessments conducted within the Contractor's Service Area, including those that may have been conducted by Community partners and other organizations;
- f. Prior to finalizing, Contractor shall provide a draft of its CHA to the IHCPs who participated in its development and drafting and allow such IHCPs to review and provide feedback thereto. The feedback provided by the IHCPs must, to the extent it is based on findings made by the IHCPs and others who participated in the development of the CHA, be incorporated into the CHA before finalizing and providing it to OHA for review and approval.
- g. If Contractor was not a party to a Predecessor Agreement with OHA prior to entering into this Contract, Contractor must provide a copy of its first CHA to OHA via Administrative Notice on or before June 30, 2021. OHA reserves the right to require Contractor to revise its CHA based on Contractor's failure to meet the criteria set forth in this Section 6, Ex. K. In the event OHA requires Contractor to revise its CHP, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.
- h. If Contractor has (i) been a party to a predecessor agreement with OHA prior to entering into this Contract, (ii) drafted a CHA on or before the Effective Date of this Contract, and (iii) not previously provided such CHA to OHA, Contractor must provide a copy of its most recent CHA to OHA by June 30, 2020 for review and approval in accordance with Para. g above of this Sec. 6, Ex. K.
- i. In the event Contractor has drafted a CHA on or before the Effective Date of this Contract and such CHA, even if previously approved by OHA: (i) is not representative of the Contractor's Service Area, or (ii) has not been updated, as required under OAR 410-141-3145, within the previous five years, Contractor must update its CHA and provide a copy to OHA on or before June 30, 2021 in accordance with Para. g above of this Sec. 6, Ex. K.
- j. Utilizing the results of its CHA and other reliable data, Contractor, with its CAC, shall develop baseline data on health disparities within Contractor's Service Area. Contractor may seek guidance from the OHA Office of Equity and Inclusion in developing its baseline data.
- k. Contractor must promptly make its CHA widely available to the public after OHA's confirmation of receipt of CHA.
- l. Pursuant to OAR 410-141-3145, Contractor must update its CHA every five years; however, nothing in this Contract precludes Contractor updating the Report more frequently.

7. Community Health Improvement Plan.

- a. Utilizing the results documented in its CHA, Contractor, with the Collaborative CHA/CHP Partners, shall develop and draft a Community Health Improvement Plan in accordance with ORS 414.627, ORS 414.629, and OAR 410-141-3145. The CHP will serve as Contractor’s strategic plan for developing a population health and health care system plan that will serve the Communities within its Service Area. Contractor’s CHP is subject to adoption by its CAC.
- b. The development and drafting of the CHP must be transparent and public. Therefore, Contractor must meaningfully and systematically engage and collaborate with representatives of local government, local Tribal Organizations, community partners and stakeholders, and critical populations to create its CHP, which must include local public health authorities, local mental health authorities, Hospitals, Indian Health Care Providers, other CCOs, and federally recognized Tribes when such parties share Contractor’s Service Area.
- c. The CHP must describe the health priorities goals and strategies that govern the activities, services, and responsibilities that Contactor will undertake and implement in order to address the population health needs and resources of the Communities within Contractor’s Service Area as documented in its CHA. The CHP must be based on all the required elements of the CHA.
- (1) The baseline data on the integration of SBHCs with the larger health system or disparities and other health needs documented as a result of the work done under Para. j, Sec. 6 above of this Ex. K;
- (1) The priorities, goals of the CHP. If doing so would advance the goals of the CHP, then, and objectives identified in the CHP must include strategies for doing so;
- (2) Include a plan and strategies for improving the integration of all services provided to meet the needs of children, adolescents, and families;
- (3) Focus on creating a plan and strategies for improving the promotion and provision of primary care, Behavioral Health, and Oral Health, for children and adolescents in the Community;
- (4) A plan for improving programs that promote the health and treatment of children and adolescents in the Community, including any treatment prevention and Early Intervention programs;
- (5) Identify and include the findings of the CHA regarding health disparities among the diverse Communities within Contractor’s Service Area, including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other relevant factors. Based on such findings, include strategies for prioritizing the remediation the health disparities among such Communities; The health priorities, goals, and objectives identified in the CHP must include at least two Statewide Health Improvement Plan priorities which can be found on OHA’s website at:
- <https://www.oregon.gov/oha/ph/about/pages/healthimprovement.aspx>
- d. The health priorities, goals, and objectives identified in the CHP must include at least two Statewide Health Improvement Plan priorities which can be found on OHA’s website at:
- <https://www.oregon.gov/oha/ph/about/pages/healthimprovement.aspx>
- and may also include, without limitation:
- (1) Closing the gap on disproportionate, unmet, health-related needs;
- (2) Establishing resources for, and access to, Primary Prevention.

- (3) Building a system that provides a seamless Continuum of Care.
 - (4) Building on current Community resources and improving Community capacity to improve health or address SDOH-E, or both, and
 - (5) Engaging Communities in the development and implementation of activities and services that will fulfill or otherwise serve their needs.
- e. Contractor’s CHP must identify strategies that support the CHP health priorities and goals identified therein, and the strategies must be based on research. Such strategies may include, without limitation:
- (1) Developing health policy that supports the CHPs goals and objectives;
 - (2) Implementing community health or SDOH-E interventions, or both, to support the CHP goals and objectives, with emphasis on evidence-based interventions as available
 - (3) Developing quality improvement initiatives;
 - (4) Developing public and private resources and capacities;
 - (5) Designing and building a system of Integrated service delivery;
 - (6) Developing and implementing best practices of culturally and linguistically appropriate care and service delivery; and
 - (7) Work force development.
- f. The CHP must include metrics or indicators used to Monitor progress toward CHP goals.
- g. Contractor must also develop, with the input of school nurses, school mental health providers, and as identified in ORS 414.629 (3) other individuals representing child and adolescent health services, and include it its CHP, priorities, goals, and strategies that address the needs of children and adolescents within Contractor’s Service Area. Such priorities, goals, and strategies must include:
- (1) Identifying and obtaining existing, additional, or new funding sources that will support Contractor’s and the Community’s efforts to provide and meet the health and health care needs of children and adolescents as identified in the CHA.
 - (2) The provision of services that are effective, based on research into adverse childhood experiences, in addressing the effects of childhood trauma;
 - (3) Making recommendations relating to the improvement of, and undertaking efforts to create appropriate, suitable School Based Health Care networks and determining whether it would be advantageous to integrate with larger health systems or community care clinics;
 - (4) Integrating services in a manner that serves the needs of children, adolescents, and families;
 - (5) Developing appropriate, accessible primary care, behavioral, and Oral Health services; and
 - (6) Developing and implementing health promotion, Primary Prevention, and early intervention education and services.

- h. Prior to finalizing, Contractor shall provide a draft of the CHP to the IHCPs who participated in its development and drafting and allow such IHCPs to review and provide feedback thereto and incorporate such feedback into the final CHP. The feedback provided by the IHCPs must, to the extent it is based on findings and recommendations made by the IHCPs and others who participated in the development of the CHP, be incorporated into the CHP before finalizing and providing it to OHA.
- i. Contractor shall provide a copy of its CHP to OHA via Administrative Notice on or before June 30, 2021. OHA reserves the right to require Contractor to revise its CHP based on Contractor's failure to meet the criteria set forth in this Section 7, Ex. K. In the event OHA requires Contractor to revise its CHP, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.
- j. In the event Contractor has been performing the activities, tasks, services identified in a CHP adopted by its CAC on or before the Effective Date of this Contract and such CHP: (i) is not representative of the Contractor's Service Area, or (ii) has not been updated, as required under OAR 410-141-3145, within the previous five years, Contractor must update its CHP and provide a copy to OHA on or before June 30, 2021 in accordance with Para. h above of this Sec. 7, Ex. K.
- k. In the event OHA determines Contractor's then-current CHP no longer serves its intended purpose, OHA has the right, pursuant to OAR 41-141-3145, to require Contractor to update its CHP in less than five (5) years.
- l. Contractor shall provide an Annual CHP Progress Report to OHA on annual basis the progress it has made in developing or implementing its CHP. The Annual CHP Progress Report is due to OHA, via Administrative Notice, by June 30 of each year.
 - (1) All Annual CHP Progress Reports shall document the progress made toward the goals, benchmarks, and targets for priority areas as identified in the CHP and include all of the following information:
 - (a) Changes in Community health priorities, resources or community assets;
 - (b) Strategies used to address the health priorities identified in the CHP;
 - (c) Parties outside and within the Community who have been involved creating and implementing strategies used to address CHP health priorities;
 - (d) Progress and efforts made (including services provided and activities undertaken) to date toward reaching the metrics or indicators for health priority areas identified in the CHP; and
 - (e) Identifies the data used, and the sources and methodology for obtaining such data, to evaluate and validate the progress made towards metrics or indicators identified in the CHP.
 - (2) The Annual CHP Progress Reports must also include, as an appendix to such Reports, a completed questionnaire which is located at:
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-CHIP.aspx>

8. Social Determinants of Health and Equity Spending Programs

- a. Contractor shall submit to OHA, by June 30, 2020, an SDOH-E Spending Programs Plan that includes information regarding Contractor's plan for the implementation of spending funds during Contract Years one and two to address Social Determinants of Health and close the gap in

health disparities. Such Plan shall identify how Contractor will implement the requirements for two different Programs, the BUILD Fund and the SHARE Initiative as such Programs are described below in this Sec. 8, Ex. K.

- (1) In Contract Year one the SDOH-E Spending Programs Plan shall include a two-year plan for the BUILD Fund, and a one-year plan for the SHARE Initiative. Commencing in Contract Year two, Contractor shall be responsible for annually updating or otherwise revising its SHARE Initiative Plan.
- (2) For Contract Year one (2020), Contractor shall draft, using the reference documents posted on the CCO Contract Forms Website, the BUILD Fund and the SHARE Initiative Spending Programs plans in one document. Once drafted, the SDOH-E Spending Programs Plan for Contract Year one shall be submitted to OHA via Administrative Notice for review and approval. In the event OHA does not approve such Plan for failure to meet the requirements of this Sec. 8, Ex. K, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract subject to the following:
 - (a) In the event Contractor’s BUILD Fund two-year spending plan does not comply with the requirements of this Section 8, Ex. K, Contractor shall have only one opportunity to revise its two-year BUILD Fund spending plan, which must be completed and submitted back to OHA via Administrative Notice within seven (7) days of Contractor’s receipt of OHA’s notice of disapproval. In the event Contractor’s revised BUILD Fund spending still does not comply with the requirements herein, Contractor shall not be eligible to receive the Withhold amounts that may be paid out in Contract Year two (2021) as more fully described in Sec. 1, Para. b of Ex. C of this Contract.
- (3) Such documented Plans must include, at a minimum, all of the following:
 - (a) SDOH-E priorities identified by Contractor in its Application to the RFA as vetted through stakeholders and clearly noting any modifications since its Application was submitted. Such SDOH-E priorities must: (i) be aligned with, if one is in existence, Contractor’s most recent CHP that is shared with the Collaborative Partners, as defined in 410-141-3145, including local public health authorities and local Hospitals, or as identified by Contractor as a result of its analysis of any existing CHPs adopted by CCOs, Hospitals, and local public health authorities that provide services within Contractor’s Service Area; (ii) meet the OAR SDOH-E definition, falls into one or more of four SDOH-E domains: **Economic Stability, Neighborhood and Built Environment, Education, and Social & Community Health** (as such domains are identified in the SDOH-E Spending reference document); and (iii) include plans to address any additional priorities as identified in the SDOH-E Spending Programs described in this contract;
 - (b) At least one spending priority that aligns with the OHA-designated statewide priority for SDOH-E spending in housing-related services and supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities as set by OHA;
 - (c) A narrative that demonstrates that the Spending Plan will meet all requirements for SDOH-E Spending as specified in OAR and this Contract; and

- (d) A narrative that describes any infrastructure needs or gaps for addressing the selected priorities and ways to satisfy those needs or gaps.
- b.** For all Contract Years, the SDOH-E Spending Programs Plan will be posted publicly with appropriate redactions on OHA’s website and shared with the Oregon Health Policy Board. For all Contract Years expenditures made under the BUILD Fund and the SHARE Initiative must meet all requirements as specified in OAR 410-141-XXXX and in this Contract, including without limitation:
- (1) SDOH-E Spending priorities selected by Contractor based on:
- (a) The CCO’s most recent Community Health Improvement Plan that is shared with the Collaborative Partners, as defined in 410-141-3145, including local public health authorities and local Hospitals. If Contractor has not yet developed a shared CHP, Contractor shall look to CHPs developed by other stakeholders in the Service Area, such as local public health authorities, Hospitals, and other CCOs;
- (b) At least one priority that aligns with the OHA-designated Statewide priority for SDOH-E spending in housing-related services and supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities as set by OHA; and
- (c) Alignment with the Contractor’s Transformation and Quality Strategy.
- (2) A portion of SDOH-E Spending Program expenditures must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, to address the Social Determinants of Health and Equity as agreed by Contractor. Contractor shall enter into a contract with each SDOH-E Partner that defines the services to be provided and the CCO’s data collection methods as provided in this contract.
- (3) CCOs shall designate a role for the CAC in directing, tracking, and reviewing spending on SDOH-E, as described in OAR.
- c.** Contractor shall provide, as requested by OHA from time to time and at least annually, an SDOH-E Spending Report that shall include narratives and financial reporting of SDOH-E related expenditures. The SDOH-E Spending Report shall identify expenditures related to the SHARE Initiative and the BUILD Fund (as such Initiative and Fund are described below in this Ex. K), and shall be provided in the manner, means, and form prescribed by OHA via Administrative Notice to Contractor’s Contract Administrator. Guidance documents and templates for the SDOH-E Spending Report are posted on the CCO Contract Forms Website.
- d.** Within thirty (30) days after a SDOH-E Partner Subcontract has been executed by both Contractor and the SDOH-E Partner, Contractor shall provide a copy of the fully executed SDOH-E Partner Subcontract to OHA via Administrative Notice in accordance with Sec. 12 of Ex. B, Part 4 of this Contract. The fully executed Subcontract must be accompanied with the completed SDOH-E Subcontract Cover Sheet and a completed Subcontractor and Delegated Entities disclosure form located on the CCO Contracts Forms Website.
- (1) Contractor’s proposed Subcontract for its SDOH-E Partners must comply with all of the terms and conditions set forth in Sec. 12, Ex. B, Part 4 of this Contract. In addition, Contractor’s SDOH-E Partner Subcontracts must also include the following information and disclosures:
- (a) The type of SDOH-E partner;

- (b) Any relationship or financial interest that may exist between the SDOH-E partner and Contractor, including membership on Contractor’s governance board or CAC;
 - (c) Identify the SDOH-E spending priority or domain for which the SDOH-E Partner is required to provide services;
 - (d) How the SDOH-E funds will be paid to the SDOH-E Partner
 - (e) The scope of work to be performed, including:
 - i. Specific services to be provided;
 - ii. Which populations will be provided services or otherwise be beneficiaries of the SDOH-E Partner’s services (e.g., Members, Community members);
 - iii. Whether Contractor will refer Members to the SDOH-E Partner;
 - iv. The geographic area the SDOH-E Partner will cover;
 - v. How Contractor will measure and evaluate outcomes;
 - vi. Include standards and agreements with respect to compliance with HIPAA and HITECH; and
 - vii. Data reporting and data collection obligations by and between Contractor and the SDOH-E Partner including:
 - A. The data elements to be collected;
 - B. The data elements to be shared by the SDOH-E Partner with Contractor;
 - C. The data elements to be shared by Contractor with the SDOH-E Partner;
 - D. How the SDOH-E Partner will, on behalf of Contractor, collect and report data related to outcomes;
 - E. How people are tracked in the intervention; and
 - F. Frequency of submission reports.
- e. **Boosting Up Investments in Long-term Development for SDOH-E Fund.** Amounts to be spent under the BUILD Fund will be contingent on the availability of funds under the Medicaid Growth Cap and funding within the OHA budget as determined by OHA’s Director. Whether such funds are available for Contract Year one (2020) will be determined on or before October 1, 2019 and identified in the SDOH-E Spending Programs Plan Template located on the CCO Contract Forms Website. If sufficient funds are available for Contract Year two (2021), OHA will advise Contractor of the fixed amount of revenue required to be spent during Contract Year two (2021), in the then-updated SDOH-E Spending Programs Plan Template, which will be posted on the CCO Contract Forms Website. In the event OHA determines the necessary funds are available in accordance with this Para. e, Ex. K, the BUILD Fund will be undertaken as follows:
- (1) By October 1, 2019 OHA will provide Contractor with a schedule of the amounts required to be spent under the BUILD Fund during Contract Year one.

- (2) BUILD Fund spending must meet all requirements for SDOH-E Spending Programs Plan expenditures described in this Contract. Additionally, spending must meet one or more of the capacity building needs in the following four key areas:
- (a) **Social determinants of equity:** Build capacity for addressing the Social Determinants of Equity, especially for ensuring equity in strategies that meet other BUILD Fund objectives; systemic or structural factors that shape the distribution of the social determinants of health in communities;
 - (b) **Screening:** Build infrastructure and capacity for screening of Members for social needs, including capturing and reporting of data;
 - (c) **Referral:** Build infrastructure and capacity for closed-loop referrals and/or navigation to social resources; and
 - (d) **Partnership-building:** Strengthen partnerships and resolve barriers between plans/medical providers and SDOH-E partners, for the purposes of partnerships that support referral to social resources or population-level SDOH-E interventions, or both.
- (3) OHA will determine whether to increase the risk margin in CCO capitation rates for Contract Year two (2021), based primarily on two factors:
- (a) Availability of funds, based on the Medicaid growth cap and funding within OHA’s budget, as determined by the OHA director; and
 - (b) Contractor’s submission of a provisional spending plan in Contract Year one (2020) that meets the requirements of this Contract.
- (4) Without limiting any other provision of this Contract, failure to spend all of the BUILD Funds in accordance with this Sec. 8, Ex. K shall be deemed a breach of this Contract. In order to remedy such breach, Contractor shall provide OHA with a proposed BUILD Fund Spending Corrective Action Plan for spending the necessary BUILD Funds within a time period acceptable to OHA. In the event Contractor is required to create and implement a BUILD Fund Spending CAP, Contractor must provide such Plan to OHA via Administrative Notice for review and approval no later than February 15 of Contract Years two (2021) and three (2022), as may be applicable. In the event such CAP is not approved by OHA, Contractor shall follow the process set forth in Sec. 5 of Ex. D.

f. Supporting Health for All through Reinvestment Initiative. Commencing in Contract Year two, Contractor shall spend a portion of its previous calendar year’s net income, or reserves that exceed the financial requirements prescribed by OHA, in accordance with OAR 410-141-XXXX, ORS 414.625(1)(b)(C) (as such statute was amended by 2018 HB 4018), and this Contract, on services designed to address health disparities and the SDOH.

- (1) Commencing in Contract Year two, Contractor shall annually submit to OHA for review and approval, its SHARE Initiative Spending Plan identifying how Contractor intends to direct its SDOH-E spending for the SHARE Initiative. The proposed final SHARE Initiative Spending Plan shall be submitted to OHA via Administrative Notice by June 30 of each Contract Year. In the event OHA does not approve the its SHARE Initiative Spending Plan Contractor shall, in order to remedy the deficiencies in its SHARE Initiative Spending Plan, follow the process set forth in Sec. 5, Ex. D of this Contract. The SHARE Initiative Spending Plan shall include the following, without limitation:

- (a) A list of current spending priorities for all SDOH-E spending that are aligned with the Contractor's CHP as described in OAR 410-141-AAAA, including the Statewide priority of housing-related services and supports, including Supported Housing.
 - (b) Justification of any changes from priorities in Contractor's SHARE Initiative Spending Plan for Contract Year one;
 - (c) Identify how the SHARE Initiative Pending project(s) or initiative(s) address a priority area of SDOH-E, as identified in Sub. Para. (1)(a) above of this Para. f, Ex. K.;
 - (d) Identify the SDOH-E Partner(s), with demonstrated experience delivering services or programs, or supporting policy and systems change, or both, to address SDOH-E, that will receive a portion of SHARE Initiative funding;
 - (e) A description of how SDOH-E Partners were selected for SHARE Initiative project(s) or initiative(s);
 - (f) Any ownership, business, or financial relationship between SDOH-E Partners and Contractor, related to SHARE Initiative spending, including a completed ownership disclosure form;
 - (g) A budget proposal indicating the amount of funding from the SHARE Initiative that will be put toward each project or initiative, including the amount of funds that will be directed to each SDOH-E Partner; and
 - (h) A description of the CAC's role in directing, tracking, and reviewing the proposed projects or initiatives (or both).
- (2) Contractor's SHARE Initiative Spending Plan may, but is not required to include, the following:
- (a) An evaluation plan for each project or initiative, including expected outcomes, the projected number of Contractor's Members, OHP members, and other Community Members served, and how impact will be measured; and
 - (b) If the project requires data sharing, a proposed data sharing agreement that details the obligation for SDOH-E partner to comply with HIPAA, HITECH and other Applicable Laws regarding privacy and security of personally identifiable information and Electronic Health Records and hard copies thereof.
- (3) The portion of required SHARE Initiative spending for each Contract Year of this Contract must be spent down within two years of OHA's approval of the SHARE Initiative Spending Plan. Contractor may request from OHA an extension of time of up to one year from OHA's initial approval to completely spend down its SHARE Initiative. All such requests must be made at least 90 days prior to the expiration of the two-year period. OHA shall have the right to disapprove a request for extension of time in its reasonable discretion. Requests for extensions of time must be submitted to OHA via Administrative Notice.
- (4) In the event Contractor terminates this Contract, or has its Contract terminated by OHA, prior to SHARE Initiative Funds being spent down, as required under this Contract, all

remaining SHARE Initiative funds must be spent in compliance with these contract terms as a part of its Transition Plan.

9. Health-Related Services

- a.** In addition to Covered Services, Contractor shall provide and cover the cost of Health-Related Services in accordance with criteria set forth in OAR 410-141-3150 and 45 CFR §158.150 (including those services identified in 45 CFR §158.151) provided that such Services are consistent with: (i) the goal of achieving Member wellness, (ii) the objectives of providing individualized care plans, and (iii) the goal of improving population health and health care quality. Health-Related Services must be coordinated by Contractor but may be provided in collaboration with the PCPCHs or other PCPs in Contractor's Service Area. Health-Related Services must be administered in accordance with Contractor's policy.
- b.** Contractor and its CAC shall align Health-Related Services Community Benefit Initiatives (as such services are defined in OAR 410-141-3150) with Community priorities as they are identified in Contractor's then-current CHP and as otherwise directed in writing by OHA.
- c.** Services covered under this Contract may be substituted with or expanded to include Health-Related Services in compliance with Contractor's policy. In addition, each Member, and as may be appropriate, the family of the Member, must agree that the substituted or expanded Health-Related Services is an acceptable alternative.
- d.** Contractor shall draft and adopt written Health-Related Service Policies which shall address Contractor's policies and procedures for the provision of Health-Related Services. Contractor's Health-Related Service Policies must comply with OAR 141-410-3150 and OAR 141-410-3000, and also identify:
- (1) How Contractor will decide whether and when Health-Related Services are provided and paid for;
 - (2) What types of Health-Related Services are provided and paid for;
 - (3) How Health-Related Service providers can become eligible to provide services to Contractor's Members;
 - (4) Processes for requesting funding for Health-Related Services and processes regarding the awarding of funds for Health-Related Services;
 - (5) Processes to enable alignment between Contractor's Health-Related Service investments and CHP priorities;
 - (6) Procedures and processes for Monitoring funds spent on, and commencing in Contract Year two, an analysis of how that spending correlates to, the effectiveness of Health-Related Services and how such analysis has impacted any change in Contractor's Health-Related Services Policies;
 - (7) The role of the CAC and tribes in determining whether investments are made, and what amount should be invested, in community benefit initiatives; and
 - (8) Processes to notify individual members and providers of the outcome of health-related services requests.

- e. Contractor's Health-Related Service Policies must enable a Participating Provider to order and supervise the delivery of Health-Related Services. Contractor shall provide its Health-Related Service Policies to OHA for review and approval, as follows:
- (1) Via Administrative Notice annually no later than October 1st.
 - (2) Via Administrative Notice Within twenty (20) Business days of any material change whether such changes are made prior to or after approval by OHA and formal adoption by Contractor; and .
 - (3) Via Administrative Notice within five (5) Business Days after OHA request.
- f. OHA will provide Contractor's Contract Administrator with Administrative Notice of OHA's approval of its Health-Related Service Policies within thirty (30) days of receipt. In the event OHA does not approve Contractor's Health-Related Service Policies, Contractor shall, in order to remedy the deficiencies in such Policies, follow the process set forth in Sec. 5, Ex. D of this Contract.

10. Health Equity Plans

Pursuant to 2018 HB 4018B, Contractor must develop and implement a Health Equity Plan designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among Contractor's Members and the Communities within Contractor's Service Area.

a. Development of Health Equity Plan - Overview

- (1) Contractor shall develop and begin to implement its Health Equity Plan by the beginning of Contract Year 2020. Contractor's Health Equity Plan shall include the elements identified in this S. 10 below of Ex. K, and be developed utilizing OHA's Health Equity Plan guidance documents and if requested by Contractor, with technical assistance from OHA. The Health Equity Plan guidance documents are located on the CCO Contract Forms Website.:
- (2) In order to support the effectiveness and efforts of Contractor's Health Equity Plan, Contractor shall hire or designate an existing employee to serve as an Health Equity Administrator. The HE Administrator shall serve as the single point of accountability who will be responsible and accountable for all matters relating to Health Equity within Contractor's organization, Provider Network, and Service Area. The HE Administrator must be a high-level employee (e.g. director level or above) but may have more than one area of responsibility and job title. For illustration purposes only, the HE Administrator may be a director of human resources, vice president of compliance, and the like. The HE Administrator must have the authority to communicate directly with Contractor's executives and governing board. The scope of the HE Administrator's responsibilities shall include, without limitation: (i) the development and implementation of Contractor's Health Equity Plan, (ii) Making themselves available to, or as requested from time to time, or as such HE Administrator may determine is appropriate from time to time, participate in Health Equity Committees and other related workgroups; (iii) facilitation of the transmission of information between and among OHA, the Health Equity Committee, and Contractor, regarding Health Equity activities; (iv) ensuring Contractor, its Provider Network, and all other Subcontractors deliver of Culturally and Linguistically Appropriate services; and (v) responsibility for budgetary, personnel, and other resource allocations.

- (3) Contractor shall provide its Health Equity Plan to OHA by March 15, 2020. Thereafter Contractor shall provide OHA with an updated Health Equity Plan annually by no later than March 15 of each Contract Year. Contractor shall provide OHA with its Health Equity Plan, via Administrative Notice, for review and approval. OHA will approve Contractor's Health Equity Plan if it is in compliance with the criteria set forth in this Contract and all Applicable Laws. In the event OHA does not approve Contractor's Health Equity Plan, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract.
- (4) In developing its Health Equity Plan Contractor must include strategies, objectives, activities, and policies that will result in the advancement of health equity in Contractor's Service Area as described in more detail in Para. c below of this Sec. 10, Ex. K.
- (5) Contractor's Health Equity Plan shall be comprised of three main sections as follows:

 - (a) Narrative of the Health Equity Plan development process, including meaningful Community engagement;
 - (b) Focus areas, strategies, goals, objectives, activities, and metrics; and
 - (c) Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan.

b. Narrative Health Equity Plan Development and Implementation - Requirements

The Narrative Section of Contractor's Health Equity Plan shall include a description of each of the following components:

- (1) Contractor's organization and organizational commitment to Health Equity;
- (2) The general population of those residing in Contractor's Service Area, Contractor's workforce demographics, and CAC demographic composition. This narrative shall also identifying the data sources used to identify the demographic criteria relied upon to choose its CAC members. If Member demographic data is available, Contractor shall also include that information;
- (3) Contractor's organizational oversight and accountability structure that serves to support the implementation of the Health Equity Plan components, including the identification of Contractor's HE Administrator and a description that includes, without limitation, of such Administrator's: (a) role and responsibilities, (b) authority to (and supporting evidence thereof) to make decisions regarding budget, personnel, and other resources; and (c) the organizational mechanisms for reporting to and otherwise communicating with Contractor's executives and governing board.
- (4) How the Health Equity Plan was developed, including the meaningful involvement of its Health Equity Stakeholders, e.g. Members, CAC, and other Community stakeholders, in the development of Contractor's Health Equity Plan as well as the involvement of such parties in the annual update of the Health Equity Plan. Contractor is expected to provide specific evidence that the process for the development of the Health Equity Plan included clearly defined and realistic objectives that were informed by HE Stakeholders. Such evidence may include: (i) a list of the HE Stakeholders involved, (ii) a description of how HE Stakeholder engagement impacted the plan development process; (iii) how Contractor informed potential HE Stakeholders of the process of the proposed development, implementation, and outcomes; and (iv) how Contractor plans to

communicate regular updates to those HE Stakeholders who were involved in the development process;

- (5) Contractor’s timeline for implementing the Health Equity Plan;
- (6) Contractor’s plan for communicating and engaging the Community in the development, implementation, and evaluation of the Health Equity Plan and deliverables;
- (7) The processes of analysis used to assess Contractor’s organizational capacity to advance health equity, including meaningful stakeholder engagement, current capabilities and assets, and future goals for developing additional capacity and obtaining additional assets within Contractor’s organization and throughout its Service Area; and
- (8) For each strategy employed (as detailed below in Para. c below of this Sec.10, Ex. K), the Contractor’s expectations relating to the impact that the Health Equity Plan will have on SDOH and Community-wide efforts to reduce health inequities.

c. Strategies, Goals, Objectives, Activities, and Metrics - Requirements

Contractor may use the reference documents identified in Para. a above of this Sec. 10, Ex. K, to assist with the drafting of the strategies, goals, objectives, activities and metrics section of its Health Equity Plan, which must include:

- (1) Standards for, and measurements of success of, the implementation of the Health Equity Plan throughout the Contract Term;
- (2) During the first Contract Year(2020) , Contractor shall develop at least one strategy, for each of the focus areas listed below in this Sub.Para..(2)(a) – (h) below of this Para. c, Sec. 10, Ex. K and identify and undertake tasks and activities that align with each such strategy that will enable Contractor to: (i) make progress towards achieving, (ii) support efforts to achieve, or (iii) achieve , Health Equity. OHA reserves the right to change, expand, or otherwise modify the focus areas listed below. Accordingly, Contractor must promptly develop and implement at least one strategy for each of the following focus areas: :
 - (a) A Grievance and Appeal System that complies with the terms and conditions of Ex. I of the Contract, is Culturally and Linguistically Appropriate, and complies with Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, Title III of the American with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973;
 - (b) Methods and processes of collecting, analyzing, and maintaining accurate and reliable demographic data of its Members, CAC members, Providers, and Contractor’s employees. Such data collected must include data points relating to race, ethnicity, language, and disability ;
 - (c) Providing: (i) effective, equitable, understandable, and respectful quality care and services, including, without limitation, free-of-charge certified or qualified oral and sign language interpreters, to all Members, and (ii) accessible health and healthcare services for individuals with disabilities in accordance with Title III of ADA
 - (d) Organizational governance systems that promote health equity through the delivery of CLAS;

- (e) Recruitment strategies and processes that result in the hiring of **competent leadership and a workforce** that is reflective of the REAL+D demographics of Contractor’s Service Area;
 - (f) Training and education for Contractor’s governing board, leadership, Provider Network, and workforce that provides such parties with the awareness and tools that will enable such parties to be culturally and linguistically responsive to the REAL+D demographics in Contractor’s Service Area (i.e. **Training activities such as Non-discrimination and civil rights, compliance with Section 1557 of the Affordable Care Act, utilization of Traditional Health Workers, Community engagement, accessibility, among others criteria**);
 - (g) Resources invested, processes and tracking mechanisms developed to ensure Contractor provides readily available, high-quality, appropriate language assistance services (i.e. development of a language access plan that: (i) builds the resources necessary for Members to have ready access to, and use of, OHA qualified or certified healthcare interpreters; (ii) actively promotes such services with Contractor’s Members and Provider Networks, and (iii) enables Contractor to perform quality assessments of such language interpreter services), which are reflective of the REAL+D demographics in Contractor’s Service Area, and in compliance with Section 1557 of the Affordable Care Act and other Applicable Laws.
 - (h) Development and use of Member educational and other **materials (print, multimedia, etc.)**, that are in plain language and alternate formats, utilizes IT and other tools and resources for Members who are blind or deaf, or otherwise disabled (e.g. literacy programs).
- (3) OHA shall have the right to amend or modify the above focus areas from time to time in accordance with Para. f below of this Sec. 10, Ex. K.

d. Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan- Requirements

- (1) As set forth in further detail below in this Para.d, Sec.10, Ex. K, Contractor shall provide and incorporate Cultural Responsiveness and implicit bias continuing education and trainings into its existing organization-wide training plans and programs.
- (2) The trainings must align with the components of a cultural competence curriculum set forth by OHA’s Cultural Competency Continuing Education criteria listed on OHA’s website located at:
https://www.oregon.gov/oha/OEI/Documents/OHA%20CCCE%20Criteria_May2019.pdf
Contractor may utilize OHA pre-approved trainings to meet its obligations under this Para. d, Ex. K, which Contractor may access at OHA’s website located at:
https://www.oregon.gov/oha/OEI/Documents/CCCE%20Registry_041919.pdf
However, Contractor may develop its own curricula and trainings subject to: (i) alignment with the cultural competencies identified in the “Criteria for Approval Cultural competence Continuing Education Training” document located in the URL above, and (ii) prior written approval by OHA.

- (3) Contractor shall adopt the definition of Cultural Competence set forth in OAR 943-090-0010 and utilize such definition to guide its development of Cultural Responsiveness materials and topics in its Cultural Competence Continuing Education training activities into its training plans for Health Care Professionals.
- (4) Contractor shall ensure that all of its employee and Provider Network ~~training offerings include~~, at a minimum, the following fundamental areas or a combination of all:
- (a) Implicit bias/addressing structural barriers and systemic structures of oppression.
 - (b) Language access (including the use of plain language) and use of ~~Health Care Interpreters~~, including without limitation, the use of Certified or Qualified Healthcare and American Sign Language interpreters.
 - (c) The use of CLAS Standards in the provision of services. About which additional information may be found at the following URL <https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>.
 - (d) Adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma.
 - (e) Uses of REAL+D data to advance health equity.
 - (f) Universal access and accessibility in addition to compliance with the ADA, and
 - (g) Health literacy.
- (5) Contractor shall provide and require all of its employees, including directors, executives, to participate in all such trainings. Contractor shall incorporate fundamental areas of Cultural Responsiveness and implicit bias training and trainings relating to the use of healthcare interpreters in all new employee orientations. In addition, Contractor shall provide and require all new employees receive training and educational activities that address the fundamental areas of cultural responsiveness, implicit bias, and the use of health care interpreters. Such training must be provided to all new employees upon commencement of employment or at new employee orientation but in no event shall Contractor delay providing such training to new employees or otherwise wait for Contractor's regular annual cycle of trainings to be offered to all of Contractor's employees.
- (6) Contractor shall also require and provide Cultural Responsiveness and implicit bias training, or ensure such training is provided, to all of Contractor's Provider Network and Provider Network staff. Such trainings and all reporting must comply with the requirements set forth in this Para. d, Ex. K of this Contract.
- (7) Contractor shall set training goals and objectives that comply with the criteria set forth in Para. d above of this Sec. 10, Ex. K. Contractor must also develop and implement review processes of such training using criteria such that the review process will enable Contractor and OHA to Monitor and measure both the qualitative and quantitative progress, impact, and effectiveness of all training and education provided by Contractor..
- (8) Contractor shall provide written documentation to OHA of the Cultural Responsiveness and other related education and training that it will provide to its employees and Provider Network in Contract Year one (2020). The documentation shall include a timeline for

providing all required education and training activities, goals and objectives, and evidence Contractor's adoption of the criteria and core competencies set forth in this Para. d, Sec. 11, Ex. K. Such documentation shall be provided to OHA via Administrative Notice by no later than March 15, 2020.

- (9) Contractor shall also provide OHA with an Annual Training and Education Report that documents all of the previous Contract Year's training activities, including, without limitation, reporting of training subjects, content outlines and materials, assessment of goals and objectives, target audiences, delivery system, evaluations, training dates and hours, training attendance, and trainer qualifications. Contractor shall also include in its Annual Training and Education Report its training and education plan for the then-current Contract Year. Contractor shall provide its Annual Training and Education Report to OHA via Administrative Notice on March 15 of each Contract Year together with its Updated Health Equity Plan and Annual Health Equity Assessment Report. The Annual Health Equity Assessment Report template can be found on the CCO Contract Forms Website. OHA shall have the right to review and approve Contractor's annual training and education plan for compliance with this Section 10, Ex. K. In the event OHA does not approve Contractor's training and education plan, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract. Plan.

e. Annual Health Equity Assessment Report

- (1) Beginning in Contract Year 2021, Contractor shall provide OHA with an Annual Health Equity Report that evaluates Contractor's Health Equity Plan. Contractor shall provide OHA, via Administrative Notice, with its Annual Health Equity Assessment on March 15 of each Contract Year together with its Updated Health Equity Plan and Annual Training and Education Report. Contractor shall include in its Annual Health Equity Report an assessment of progress made with respect to the strategies, tasks, and activities for each of the focus areas identified in Para. c above of this Sec. 10, Ex. K. and as set forth in Contractor's Health Equity Plan and Updated Health Equity Plan and other relevant information relating to:
- (a) For Contract Year one (2020) only, a description of implementation efforts.
- (2) For Contract Years two through five, Contractor's Annual Health Equity Report shall comply with the criteria set forth in Sub. Para. (1) above of this Para. e, Sec. 10, Ex. K, and also include an assessment of progress made with respect to the strategies, tasks, and activities for each of the focus areas identified in Para. c above of this Sec. 10, Ex. K. and as set forth in Contractor's Health Equity Plan and Updated Health Equity Plan and other relevant information relating to:
- (a) Contractor's progress on organizational capacity for health equity and cultural responsiveness;
- (b) How Contractor has used and integrated considerations of REAL+D and CLAS in the organization and the Provider Network; and
- (c) Information relating to Contractor's Cultural Responsiveness and implicit bias training activities, whether provided to Contractor's Provider Network or employees and staff, that is substantially similar to the information required to be provided under Sub Para. (6), Para. d, above of this Sec. 10, Ex. K.

(3) Contractor's Annual Health Equity Report shall be provided to OHA via Administrative Notice simultaneously with its updated Health Equity Plan (i.e. by no later than March 15 of each Contract Year).

f. OHA reserves the right, to amend or modify the focus areas identified in Para. c above of this Sec. 10, Ex. K. Such amendment or modification shall be based on: (i) the results identified by OHA in its review of Contractor's Annual Health Equity Report, as well as the results documented by other CCOs, and (ii) recommendations made, in collaboration with OHA, the Oregon Health Policy Board Health Equity Committee..

11. Traditional Health Workers

a. Contractor shall implement the THW Integration and Utilization Plan developed and submitted with its Application for RFA 4690. ~~The THW Integration and Utilization Plan must describe how Contractor will:~~

(1) Integrate THWs into the delivery of services;

(2) Communicate to Members and Providers about the scope of practice, benefits, and availability of THW services;

(3) Increase Member utilization of THWs;

(4) Implement OHA's Office of Equity and Inclusion THW Commission best practices which includes Contracting with Community based organizations;

(5) Measure baseline utilization and performance over time;

(6) Utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its Provider Network.

b. Contractor shall establish a THW Payment Grid, based on OHA's and THW Commission guidelines, a payment model grid, informed by the recommendations of the THW Commissions' Payment Model Committee, that is sustainable . Contractor must provide its THW Payment Grid to OHA via Administrative Notice by no later than April 15 of each Contract Year. OHA will then post Contractor's THW Payment Grid at the following URL:

<https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>

The THW Payment Grid must include different sustainable payment strategies, including Fee-for-Service, alternative payment models such as bundled payments and per-Member per month payments, direct employment, and other strategies. In the context of the THW Payment Grid, sustainable payment strategies means strategies that enable Contractor to pay THWs on an on-going, long term basis as opposed to short or one time grants or other types of payments that result in underpayment, underemployment, or unemployment of THWs.

c. Contractor shall work in collaboration with OHA's THW Commission to implement the THW Commission's best practices to enhance organizational capacity to:

(1) Contract with Community-based organizations;

(2) align and retain THWs workforce,

(3) THWs support and supervision,

(4) Supervision competencies,

(5) understanding THWs Provider enrollment,

- (6) improve billing and payment procedures,
- (7) understand benefits of integrating individual THWs, and
- (8) understand THWs scope of practices.

Resources related to the THW Commissions best practices may be found at the following URL: <https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>.

Contractor may also request that OHA’s Office of Equity and Inclusion provide its technical assistance with Contractor’s implementation of its THW Integration and Utilization Plan.

- d. Contractor shall subcontract with a third-party, hire a new employee, or designate an existing employee, to serve as Contractor’s THW Liaison. The THW Liaison shall be a full-time employee or, if working on a contract basis, be contracted to provide services on a full-time equivalent basis. Contractor shall draft and maintain a job description for the THW Liaison which shall include responsibility for THW integration and serving as the central point of contact for communications relating to THW services. Specifically, the THW will be responsible for disseminating and otherwise communicating with Members, the Community, and THWs, and other stakeholders within Contractor’s Organization, regarding THW services available to Members within and, if applicable, outside of Contractor’s Service Area. The THW Liaison shall also be responsible for:

- (1) Addressing barriers to integration and utilization of THWs and their services;
- (2) Coordinating Contractor’s THW workforce;
- (3) Design Contractor’s THW Integration and Utilization Plan within Contractor’s Service Area to Members and increase its recruitment and retention of THWs in its operations, and to implement the provisions of its THW Integration and Utilization Plan;
- (4) Provide technical assistance to help THWs become enrolled as Provider with Contractor;
- (5) Assist and coach Members in utilizing Contractor’s THW Providers and services;
- (6) Provide assistance and support for establishing THW payments and rates;
- (7) Member access to, and utilization of, THWs in both in clinical and Community based settings; and
- (8) Assisting supervisors and managers with understanding the THW care model, scope of work, and their oversight responsibilities as well as ensuring THW Providers are integrated into a Member’s care team and the THW services an integral component of a Member’s health care treatment plan.

- e. As part of the implementation of Contractor’s THW Integration and Utilization Plan, Contractor shall include in its Member Handbook the benefits and availability of THW services. Contractor shall also clearly and consistently communicate with Members about the benefits and availability of THW services through Marketing Materials and other means and methods. All Marketing Materials and other means and methods must be CLAS appropriate and reflective of the REAL+D demographics within Contractor’s Service Area.

- f. As part of the implementation of Contractor’s THW Integration and Utilization Plan, Contractor shall communicate in writing with Providers about the availability, scope of practice, and of THW services.

- g.** Contractors must update its THW Integration and Utilization Plan annually. The updated THW Integration and Utilization Plan must be submitted to OHA via Administrative Notice for review and approval by no later than April 15 of each Contract Year. Review and approval will be provided to Contractor's Contract Administrator via Administrative Notice. In the event OHA disapproves of Contractor's THW Integration and Utilization Plan, Contractor shall follow the process set forth in Sec. 5 of Ex. D to this Contract.
- h.** During each Contract Year Contractor shall collect data to measure the integration and utilization of THWs by Members regardless of whether such utilization is within or outside Contractor's Service Area. The data collected shall be documented and reported to OHA in a THW Integration and Utilization Report using OHA's reporting template located at:

<https://www.oregon.gov/OHA/OEI/Pages/THW-Resources-Policies-Laws.aspx>.

The data collected and documented in the THW Integration & Utilization Report for each Contract Year shall be provided to OHA by no later than April 15 of the following Contract Year. Data to be collected and documented in the THW Integration & Utilization Report shall include:

- (1) An assessment of Member ~~satisfaction with THW services~~;
- (2) ~~Ratio of THWs to the total number of Members~~;
- (3) Number THWs and the type of THW, which must include the following THW types:
 - (a) Community Health Workers,
 - (b) Doulas,
 - (c) Peer Support Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists,
 - (d) Peer Wellness Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists, and
 - (e) Patient Health Navigators
- (4) whether each such THW is employed by Contractor or provides services under a Subcontract with Contractor, and if employed, is the THW a full time or part time employee;
- (5) Number of requests from Members for THW services (by THW types);
- (6) Number of times Members are referred to a THW for care or services, or both, by a person who is part of a ~~Member's Care Team (by THW types)~~;
- (7) ~~Demographics of THWs providing services to Members and how those demographics compare to the demographics of Contractor's Members. Such demographic information must include information regarding REAL+D;~~
- (8) The number of THWs who work for a clinic as part of a Care Team or who work for or otherwise provide services through a Community-based organization; and
- (9) The number of Encounters a Member has with a THW:
 - (a) in a clinical setting; and
 - (b) in a Community based setting.

- i. Contractor shall also include in its THW Integration & Utilization Report each type of payment model used by Contractor to reimburse THWs and the number of THWs paid under each payment model it utilizes.
- j. Contractor shall ensure that Encounter Data is submitted for any and all THW Encounters that are eligible to be submitted and processed for claims payment.

[Remainder of page intentionally left blank]

Exhibit L—

Solvency Plan ~~and~~, Financial Reporting and ~~Cost~~ Sustainable Rate of Growth

1. Overview of Solvency Plan ~~and Financial Reporting~~

~~a. Background/Authority~~

~~a.~~ **(1)** 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.

~~(2) 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. Solvency Plan and Financial Reporting~~

~~b.~~ Terms used in this ~~Section B~~ Exhibit L are defined in OAR 410-141-3345 to 410-141-3395, incorporated by reference herein. Contractor shall use Statutory Accounting Principles in the preparation of all financial statements and reports per OAR 410-141-3365.

2. NAIC Financial Reporting

a. General Requirements

(1) Per OAR 410-141-3365, Contractor shall file annual and quarterly financial statements with the NAIC, as described below.

(2) Such financial statements must be filed electronically with the NAIC, per the instructions on the NAIC Filings website (https://www.naic.org/industry_financial_filing.htm). Filing instructions and resources, including a [list of NAIC filing software vendors](#), are provided at the NAIC filings website. Contractor will be subject to any filing fees as imposed by the NAIC to make such filing.

(3) Contractor shall immediately (but not more than five (5) Business Days after a material change) notify OHA via Administrative Notice of a material change in circumstance from the information contained in the latest-submitted NAIC financial statement. See guidelines for amending the financial statement set forth on the NAIC filings website.

(4) Contractor shall send two hard copies of its NAIC filings electronically to OHA via Administrative Notice, on the same date as its NAIC filings.

~~a. Annual Financial Statements and Supplemental Filings~~

~~(1) Contractor shall submit all the annual financial statements per OAR 410-141-3365 and reports described below to NAIC, by ~~March 1~~ April 30 of each year covering the immediately preceding calendar year ending on 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.~~

(1) (2) Contractor shall file the annual financial statements per the instructions on the NAIC Filings website with NAIC, using the NAIC Annual Blank for Health insurers.

- ~~(3) Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3365.~~
- ~~(4) 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.~~
- (2)** ~~(5)~~ In accordance with NAIC annual statement instructions, Contractor shall include 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.
- (3)** ~~(6)~~ Contractor shall ~~prepare and file by March 1 of each year~~ a risk-based capital report as required by OAR 410-141-3360.
- (4)** ~~(7)~~ 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.
- (5)** ~~(8)~~ Contractor shall file a holding company registration statement ("Form B ~~filing~~Filing") as required by OAR 410-141-3385. ~~The Form B filing is due annually on or before April 30.~~
- ~~(9) Contractor shall file supplemental reports electronically to OHA. OHA shall, via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly/Annual Financial Reports (referred to as the "Exhibit L Financial Reporting Template"). Definitions and instructions for completing each report is included within the Exhibit L Financial Reporting Template as well as an annotation as to whether the individual report is due Quarterly or Annually and the respective due dates. 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.~~
- ~~(10) Contractor shall prepare and file with its annual statement OHA's Disclosure of Compensation report included in the Exhibit L Financial Reporting Template.~~

~~b.~~ Financial Statement Filing Information and Resources

- ~~(1) Contractor shall 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 shall be submitted to OHA.~~
- ~~(2) Filing instructions and resources are provided at the NAIC filings website.~~
- ~~(3) A list of NAIC filing software vendors is included on the web site mentioned above.~~
- ~~(4) Contractor will be subject to any filing fees as imposed by the NAIC to make such filing.~~

~~e.~~ Audited Financial Statements

- ~~(1) Contractor shall submit Audited Financial Statements through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA no later than June 1st for the year ended December 31 immediately preceding. Audited Financial Statements shall be prepared in the form required of insurers by the Insurance Code, as required by OAR 410-141-3365 and by reference to ORS 731.488 and OAR 836-011-0100 through 836-011-0220.~~

c. ~~**d.**~~ **Quarterly Financial Statements**

~~(1) Contractor shall submit quarterly financial statements per OAR 410-141-3365. 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.~~

~~(2) Contractor shall file the financial statements per the instructions on the NAIC filings website. (3) to NAIC on May 31, August 31, and November 30 of each year.~~
Contractor shall use Statutory Accounting Principles (SAP) in the preparation of all financial statements per OAR 410-141-3365 the NAIC Quarterly Blank for Health insurers.

~~(4) 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.~~

3. **Supplemental Financial Reporting**

a. **General Requirements**

Contractor shall also file annual and quarterly financial reports with OHA, as described on the OHA website, <https://dfr.oregon.gov/business/reg/insurer/instructions/Pages/index.aspx>.

~~(5) Contractor shall also file supplemental annual and quarterly reports electronically to OHA. OHA shall, via the Contract Reports Web Site, supply Contractor with an Excel workbook containing the Quarterly/Annual Financial Reports (referred to as the “Exhibit L Financial Reporting Template”) will post the Ex. L Financial Reporting Templates (which shall be in an Excel workbook format) on the CCO Contract Forms Website. Definitions and instructions for completing and submitting each report is are included within the Exhibit Ex. L Financial Reporting Template as well as an annotation annotations as to whether the individual report is due Quarterly or Annually and the respective due dates. Contractor shall submit the completed Quarterly Financial Reports to OHA through OHA’s secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA via Administrative Notice to Contractor’s Contract Administrator.~~

Reporting forms (“Exhibit L Financial Report Template” and “Exhibit L Financial Reporting Supplement SE” and collectively, the “Exhibit L Financial Report Templates”) and other tools for Contractor’s solvency plan and financial reporting are available on the CCO Contract Forms Website, and are by this reference incorporated into the Contract.

b. **Reports Required**

(1) Annual and quarterly Exhibit L supplemental reports are due to OHA on the same date as annual and quarterly financial statements are due to NAIC.

(2) Contractor shall file the following annual reports with its annual financial statement, using reporting forms included in the Exhibit L Financial Reporting Template:

(a) Contractor’s Disclosure of Compensation report; and

(b) Contractor’s annual report Risk Adjusted Rate of Growth.

(3) Contractor shall provide OHA with Administrative Notice a report on all financial distributions by Contractor to shareholders, equity members, parent companies or any related parties, no later than 30 days after the distribution.

4. Audited Financial Statements

Contractor shall provide OHA with its audited Financial Statements by no later than June 30th for the immediately preceding calendar year ending on December 31. The audited Financial Statements shall be provided to OHA using its SFTP website, or other report delivery mechanism as specified by OHA via Administrative Notice. Audited Financial Statements shall be prepared in the form required by OAR 410-141-33XX and by 2019 SB 1041 Section 11.

5. ~~3.~~ Assumption of Risk/Private Market Reinsurance

- a. 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.
- (1) 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 thirty (30) days of signing this Contract.
 - (2) Contractor shall not enter into a reinsurance agreement with a duration longer than one calendar year unless the agreement can be terminated at the end of a calendar year at the request of the Contractor.
 - (3) Contractor agrees to enter into a reinsurance agreement with OHA if a statewide reinsurance program is created by the state.
 - (4) Contractor shall ~~notify~~ provide OHA via Administrative Notice with notice of any change in its stop-loss or reinsurance coverage within thirty (30) days ~~of~~ after such change.
 - (5) Contractor understands and agrees that in no circumstances will a Member be held liable for any payments for any of the following:
 - (a) The Contractor's or Subcontractors' debt due to Contractor's or Subcontractors' insolvency;
 - (b) Covered Services authorized or required to be provided under this Contract to the Member, for which:
 - i. The State does not pay the Contractor; or
 - ii. The Contractor does not pay a Provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or
 - iii. 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.
 - (6) Nothing in this ~~Section~~ Ex. L, Sec. 3, limits Contractor, OHA, a Provider or Subcontractor from pursuing other legal remedies that will not result in Member personal liability for such payments.

6. ~~4.~~ Restricted Reserve and Financial Solvency Requirement

- a. Contractor shall 1) establish a 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 primary purpose of making payments to Providers in the event of the Contractor's insolvency but may also be used by OHA for other obligations of Contractor in a close-out after termination of the Contract. 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 State of Oregon](#). See OAR 410-141-3355 for the requirements for the restricted reserve.
- b. Contractors shall maintain a minimum Risk-Based Capital percentage as defined and required in OAR 410-141-3360.
- c. **Restricted Reserve Adequacy**

Appeal Process:

- (1) If at any time, OHA believes that Contractor has inadequate funds in its Restricted Reserve account, or that Contractor's Risk-Based Capital percentage as defined in OAR 410-141-3360, does not meet the requirements in OAR 410-141-3360, OHA will ~~notify~~ provide written Legal Notice to Contractor in ~~writing~~. accordance with Ex. D, Sec. 26.
- (2) Within thirty (30) days of Contractor's receipt of any ~~notice~~ Legal Notice by OHA under this Section, Contractor shall either:
 - (a) Adjust its Restricted Reserve account balance to the amount specified by OHA and provide documentation in support thereof; and, if required, develop and submit to OHA a written action plan as outlined in OAR 410-141-3360. Contractor shall provide OHA with Administrative Notice of required adjustment as well as any written action plan required to be submitted; or
 - (b) File an appeal in writing with the OHA ~~Administrator~~ via Administrative Notice stating in detail the reason for the appeal and submit detailed financial records that support the alternate amount.
- (3) If Contractor files an appeal, OHA ~~shall~~ will issue an appeal decision within forty-five (45) days of the Receipt ~~receipt~~ of the ~~Appeal~~ appeal, which shall be made to Contractor's Contract Administrator via Administrative Notice. ~~That~~ The appeal decision by OHA shall be binding upon Contractor and not subject to further appeal.

~~d. — Qualified Directed Payment to Hospitals —~~

~~Contractor shall make qualified directed payments to DRG hospitals for the amounts indicated in a monthly report created by OHA to assist Contractors in distributing Quality and Access funds to the appropriate hospital. Contractor shall submit electronic payment to an account established by the hospital within five business days after receipt of the monthly report. If an error is identified in the monthly report, the Contractor shall make the payment based on the original amount provided in the report. OHA will identify separately the correction in the following month's report and adjust the total payment amount to account for the error.~~

- (4) If an amendment to this Contract results in a claim by OHA for the recovery of amounts previously paid to Contractor by OHA, then OHA shall ensure that the recovery does not have a material adverse effect on Contractor's ability to maintain the required minimum amounts of risk-based capital.

7. e-Sustainable Rate of Growth Requirement

- a.** ~~(1)~~ Contractor shall manage its business operations so as to achieve sustainable growth targets. Contractor shall develop growth strategies and targets for each of its major categories of expenditure.
- b.** ~~(2)~~ Contractor shall annually file a report to OHA via Administrative Notice (a) setting forth Contractor's annual risk adjusted rate of growth, and (b) explaining the respects in which its growth exceeded or met its growth targets with the Exhibit L- Financial Reporting Template. Such report shall be submitted within five (5) Business Days after Contractor submits its Annual Audited Financial Statement. If Contractor does not achieve the sustainable growth target, OHA ~~will issue a corrective action plan that may include financial penalties~~ may require a Corrective Action Plan and may impose Sanctions starting in 2021. Sanctions may include reductions to quality pool or other performance-based incentive payments.

[Remainder of page intentionally left blank]

Exhibit M - Behavioral Health

Behavioral Health services administered through this ~~contract~~Contract must be designed to empower Members to live, work, and thrive in their communities. Contractor shall administer services, programs, and activities in the most integrated setting appropriate to the needs of its Members consistent with Title II Integration Mandate of the Americans with Disabilities Act and the 1999 *Olmstead* decision (https://www.ada.gov/olmstead/olmstead_about.htm).

~~1. Contractor Responsibilities~~

- ~~a. Contractor shall provide Behavioral Health services in a manner designed to:~~
- ~~(1) Improve~~must be provided to improve the transition of Members ~~into integrated settings~~ from higher levels of care;
 - ~~(2) Increase the number of Members who are supported in the community; and~~
 - ~~(3) Expand~~ into integrated settings in the Community. Sufficient and appropriate Behavioral Health services and supports that must be provided to enable Members to integrate and live successfully integrated into in the ~~community~~Community and avoid incarceration and unnecessary hospitalization.

1. Behavioral Health Requirements.

With respect to the provision of Behavior Health Care services Contractor shall do all of the following:

- a. ~~b. Contractor retains responsibility~~Be responsible for providing Behavioral Health ~~covered~~ services for all Members and ~~for providing care coordination~~Care Coordination for Members accessing non-covered ~~behavioral health~~Behavioral Health services ~~listed in Exhibit~~accordance with the applicable terms and conditions of this Contract, including without limitation Ex. B, Part 2.
- ~~e. Contractor shall not fully delegate the provision of Behavioral Health services and care coordination to another entity.~~
- ~~d. Contractor shall integrate funding at all levels of the Contractor's delivery system.~~
- ~~e. Contractor shall provide covered services within the global budget (as defined in ORS 414.025) in a fully integrated manner.~~
- ~~f. Contractor shall not separate funding for Behavioral Health and physical health care by fully delegating the responsibility for care coordination to another entity.~~
- ~~g. Contractor may enter into value based payment arrangements for quality and efficiency so long as those arrangements do not separate the performance metrics for physical and Behavioral Health services. No value based payment arrangement or any other payment methodology is permitted that reduces the Contractor's responsibility to meet the contractual requirements for care coordination and meet each individual Member's needs for services.~~
- ~~h. Contractor shall ensure the availability of service, supports or appropriate alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting.~~
- ~~i. Contractor shall review data and reports annually to assess whether its expenditures on Behavioral Health services are appropriate. Assessment should include review of EQRO reports, guidance from OHA, adherence to network adequacy and access standards such as member wait~~

~~time to appointment and travel time and distance to providers, complaints, grievances, appeals, and any other source of information for evaluating the sufficiency of Behavioral Health access for its members.~~

- ~~j. Contractor shall correct any identified deficiency in adequacy or access in a timely manner. Failure to fully remedy any deficiencies may result in corrective action or sanction pursuant to Exhibit B of this Contract.~~

~~2.~~ Covered Services

~~a.~~ Access to Services

- ~~(1) Contractor shall ensure the provision of cost-effective, comprehensive, person-centered, culturally responsive, and integrated community-based Behavioral Health services for Members.~~
- b. (2) Contractor shall ensure Ensure Members have timely access to all care in accordance with OAR 410-141-3220 and the applicable terms and conditions of this Contract, including without limitation Ex. B, Part 4.
- c. Not Subcontract with a single Provider, governmental agency, or other third party for the provision of Behavioral Health services and Care Coordination.
- d. Ensure that Services and supports meet the needs of the Member and address the recommendations stated in the Member's Behavioral Health Assessment.
- e. Arrange for the provision of Health-Related Services to Members, as required in Ex. K of this Contract, to improve a Behavioral Health condition.
- f. Adhere to CMS guidelines regarding Mental Health Parity, as required in Ex. E, Sec. 22 of this Contract.

2. Financial Matters Relating to Behavioral Health Services.

- a. Contractor shall not set a limit for Behavioral Health services within the Global Budget.
- b. (3) Contractor shall not establish a maximum financial benefit amount for Behavioral Health services available to a Member.
- c. (4) Contractor shall ~~establish written policies and procedures for Behavioral Health covered services~~ not apply any financial requirement or treatment limitation to Behavioral Health, treatment or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all physical health benefits in the same classification furnished to Members (whether or not the benefits are furnished by Contractor).
- ~~(a) Contractor shall provide the written policies and procedures to OHA by the beginning of CY 2020.~~
- ~~(b) Policies and procedures must address, at a minimum, administration of the benefit, which services have prior authorizations, and a description of the provider network, including the number of providers for each service.~~
- ~~(5) Contractor shall ensure Members have access to behavioral health screenings and referrals for treatment at multiple health system or health care entry points.~~
- d. (6) Contractor shall reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health ~~provider~~ Provider, and shall reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical ~~provider~~ Provider. (7) Contractor shall ~~ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards.~~

reimburse for multiple services provided to a Member on the same day at the same clinic or health care setting.

- e. ~~(a) Contractor shall remain responsible for coordinating~~may enter into Value Based Payment arrangements with Behavioral Health services with Non-Participating Providers and reimbursing for services., as permitted under Ex. H of this Contract.
- f. ~~(b) Contractor may cover and reimburse inpatient psychiatric services, not including substance-use disorder~~Substance Use Disorder treatment, at an Institution for Mental Diseases, as defined in 42 §CFR 435.1010, provided:
 - (1) ~~i. The~~ facility is a ~~hospital~~Hospital providing inpatient psychiatric services; ~~and~~
 - (2) ~~ii. The~~ length of stay is no more than fifteen (15) days during the period of the monthly Capitation Payment. ~~The~~;
 - (3) provision of inpatient psychiatric treatment in an ~~IMD must meet~~Institute for Mental Diseases meets the requirements for in lieu of services at 42 CFR §438.3(e)(2)(i) through (iii); ~~and~~.
 - (4) Contractor ~~must offer~~offers the Member the option to access the ~~state plan services~~Covered State Plan Services in accordance with OAR 410-141-3160 (10).

3. Integration, Transition, and Collaboration with Partners

Contractor shall do all of the following:

- a. Provide Behavioral Health services in an integrated manner, as required in Ex. B, Part 4 of this Contract.
- b. Work collaboratively with Providers in the health care continuum to improve Behavioral Health services for all Members, including adult Members with Severe and Persistent Mental Illness .
- c. Ensure that Members who are ready to transition to a Community placement are placed in the most integrated setting appropriate for the Member.
- d. Ensure that Members transitioning to another health care setting are placed consistent with the Member's treatment goals, clinical needs, and informed choice.
- e. Provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally and Linguistically Appropriate Behavioral Health services are provided in a way that Members are served in the most natural and integrated environment possible and that minimizes the use of institutional care.
- f. Engage with local law enforcement, jail staff and courts to improve outcomes and mitigate additional health and safety impacts for Members who have criminal justice involvement related to their Behavioral Health conditions. Key outcomes include reductions in Member arrests, jail admissions, lengths of jail stay and recidivism along with improvements in stability of employment and housing.
- g. Work with Providers of physical health and Behavioral Health services in the jail(s) in Contractor's Service Area to ensure timely transfer of appropriate clinical information for Members who have been incarcerated. Information shall include but is not be limited to Behavioral Health diagnoses, level of functional impairment, medications and prior history of services.

- h. Ensure access to and document all efforts to provide Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295. OHA shall have the right to request, and Contractor shall provide, via Administrative Notice within five (5) Business Days of OHA request, all documentation related to Contractor's efforts to ensure access to Supported Employment Services.

4. Policies and Procedures

Contractor shall establish written policies and procedures for Behavioral Health services, and shall:

- a. Use the template provided by OHA in developing the policies and procedures.
- b. provide the written policies and procedures to OHA by November 1, 2019 and subsequently within five (5) Business Days after request from OHA, as may be made from time to time. OHA shall review and approve such policies and procedures for compliance with this Exhibit M. In the event that OHA does not approve such policies and procedures for failure to comply with this Ex. M, Contractor must follow the process set forth in Ex. D, Sec. 5 of this Contract.

5. Referrals, Prior Authorizations, and Approvals

Contractor shall do all of the following:

- a. Ensure Members have access to Behavioral Health screenings and Referrals for services at multiple health system or health care entry points.
- b. Not require Prior Authorization for outpatient Behavioral Health services or Behavioral Health Peer Delivered Services as required in the applicable section of Ex. B, Part 2 of this Contract.
- c. Ensure Prior Authorization for Behavioral Health services comply with mental health parity regulations in 42 CFR part 438, subpart K and the requirements set forth in Ex. E, Sec. 22 of this Contract.
- d. Make a Prior Authorization determination within three (3) days of a request for non-emergent Behavioral Health hospitalization or residential care.
- e. Not require Members to obtain approval of a Primary Care Physician in order to access to Behavioral Health Assessment and evaluation services. Members shall have the right to refer themselves to Behavioral Health services available from the Provider Network.
- f. Not apply more stringent utilization or Prior Authorization standards to Behavioral Health services, than standards that are applied to medical/surgical benefits.
- g. Ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards in OAR 410-141-3220. Contractor shall be responsible for coordinating Behavioral Health services with Non-Participating Providers. Contractor shall be responsible for reimbursing for such services, including those provided outside the State when such services cannot be provided within the timely access to care standards as required under OAR 410-141-3220

6. ~~b. Assessments and Screening Members.~~

(1) Contractor shall ~~use a standardized behavioral health assessment tool, approved by OHA~~ do all of the following:

- a. Use a comprehensive Behavioral Health Assessment tool, in accordance with OAR 309-019-0135, to assist in adapting the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member.
- b. ~~(2) Contractor shall require providers to~~Require Providers screen Members for adequacy of supports for the ~~family~~Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, ~~transportation~~Transportation needs, safety needs and home visiting).
- c. Require Providers to screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have both mental illness and Substance Use Disorders.
- d. Require Providers to assess for opioid use disorders for populations at high risk for severe health outcomes, including overdose and death, including pregnant Members and Members being discharged from residential, acute care, and other institutional settings.
- e. ~~(3) Contractor shall ensure screening for all~~Require Providers to screen Members and provide prevention, early detection, brief intervention and ~~referral~~Referral to ~~Substance Use Disorders treatment who are~~Behavioral Health services in any of the following circumstances:
 - (1) ~~(a)~~ At an initial contact or during a routine physical exam;
 - (2) ~~(b)~~ At an initial prenatal exam;
 - (3) ~~(c)~~ When the Member shows evidence of Substance Use Disorders or abuse ~~(as noted in the OHA approved screening tools);~~
 - (4) ~~(d)~~ When the Member over-utilizes Covered Services; and
 - (5) ~~(e)~~ When a Member exhibits a reassessment trigger for Intensive Care Coordination needs.

7. ~~e.~~ **Substance Use Disorders Treatment**

~~(1) Contractor shall provide Substance Use Disorders (~~

- a. Provide SUD) services to Members, which ~~includes~~include outpatient, intensive outpatient, ~~medication assisted treatment including, Opiate Substitution Services,~~Medication Assisted Treatment including opiate substitution services, and residential and detoxification treatment services, consistent with OAR Chapter 309, Divisions 18, 19 and 22; and Chapter 415 ~~Division, Divisions~~ 20; and ~~OAR Chapter 415 Division~~ 50.
- b. ~~(2) Contractor shall inform~~Inform all Members, using ~~culturally responsive and linguistically appropriate~~Culturally and Linguistically Appropriate means, that ~~Substance Use Disorders outpatient, intensive outpatient, residential, detoxification and medication assisted treatment~~SUD services, ~~including opiate substitution treatment, are covered services~~ are Covered Services consistent with OAR 410-141-3300.
- c. ~~(3) Contractor shall provide Members with culturally responsive and linguistically appropriate~~Provide Culturally and Linguistically Appropriate alcohol, tobacco, and other drug abuse prevention/education and information that ~~reduces Substance Use Disorders~~reduce Members' risk to ~~Members~~Members SUD. Contractor's prevention program shall meet or model national quality assurance standards. Contractor shall have mechanisms to ~~monitor~~Monitor the use of its preventive programs and assess their effectiveness on ~~its~~ Members.

- d.** ~~(4) Contractor shall provide covered culturally responsive and linguistically appropriate Substance Use Disorders~~Provide Culturally and Linguistically Appropriate SUD services for any Member who meets American Society of Addiction Medicine (ASAM) PPC-2R placement criteria for:
- ~~(1) (a)~~ (1) (a) Outpatient, intensive outpatient, residential, detoxification, and ~~medication assisted treatment~~Medication Assisted Treatment including opiate substitution treatment, regardless of prior alcohol/~~or~~or other drug treatment or education;~~;~~ and
 - ~~(2) (b)~~ (2) (b) 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~~Referrals for persons with co-occurring disorders.
- e.** ~~(5) Contractor shall consider each Member’s needs and, to the extent appropriate and possible, provide~~Ensure that specialized ~~Substance Use Disorders, Trauma Informed, SUD~~ Substance Use Disorders, Trauma Informed, SUD services are provided in environments that are Culturally and Linguistically Appropriate, designed specifically for the following groups:
- ~~(1) (a)~~ (1) (a) Adolescents, taking into consideration adolescent development,
 - ~~(2) (b)~~ (2) (b) Women, and women’s specific issues,
 - ~~(3) (c)~~ (3) (c) Ethnically and racially diverse groups ~~and environments that are culturally responsive and linguistically relevant,~~
 - ~~(4) (d)~~ (4) (d) Intravenous drug users,
 - ~~(5) (e)~~ (5) (e) Individuals involved with the criminal justice system,
 - ~~(6) (f)~~ (6) (f) Individuals with co-occurring disorders,
 - ~~(7) (g)~~ (7) (g) Parents accessing residential treatment with any accompanying dependent children, and
 - ~~(8) (h)~~ (8) (h) Individuals accessing residential treatment with ~~medication assisted therapy~~Medication Assisted Therapy.
- f.** ~~(6) Contractor shall, where~~Where Medically Appropriate, provide detoxification in a non-~~hospital~~Hospital facility. ~~Facilities~~All such facilities or programs providing detoxification services must have a ~~letter~~certificate of approval or license from OHA in accordance with OAR Chapter 415, Division 12.
- ~~(7) Contractor shall authorize and pay for culturally responsive 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.~~
- g.** ~~(8) Contractor’s employees or providers providing Substance Use Disorders~~Provide to Members receiving SUD services ~~shall provide to Member,~~ to the extent of available ~~community~~Community resources and as ~~clinically indicated~~Medically Appropriate, information and ~~referral~~Referral to ~~community~~Community services which may include, but are not limited to: child care, elder care, housing, ~~transportation~~Transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.

h. ~~(9)~~ In addition to any other confidentiality requirements described in this Contract, ~~Contractor shall follow the~~comply with federal ~~(42 CFR Part 2)~~ confidentiality laws and regulations ~~(42 CFR Part 2)~~ governing the identity and medical/Client records of Members who receive ~~Substance Use Disorders~~SUD services.

8. ~~d.~~ **Assertive Community Treatment (ACT):**

a. ~~(1)~~ Contractor shall require that a ~~provider~~Provider or ~~care coordinator~~Care Coordinator meets with the Member face-to-face to discuss ACT services and provide information to support the Member in making an informed decision regarding participation. This must include a description of ACT services and how to access them, an explanation of the role of the ACT team ~~and~~, how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent ~~community~~Community living.

b. ~~(2)~~ Contractor shall be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation ~~—~~

~~(3)~~ ~~Contractor, and~~ shall ~~document~~:

(1) Document efforts to provide ACT to individuals who initially refuse ACT services, ~~and shall document all~~ efforts to accommodate their concerns.

~~(4)~~ ~~Contractor shall offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services.~~

(2) ~~(5)~~ Contractor shall ~~provide~~Provide alternative ~~evidence-based~~Evidence-Based intensive services if Member continues to decline participation in ACT, which must include coordination with an ~~ICC~~Intensive Care Coordinator.

c. If Contractor lacks qualified Providers to provide ACT services, Contractor shall notify OHA and develop a plan to develop additional qualified Providers in accordance with OAR 410-141-3220.

(1) Lack of capacity shall not be a basis to allow Members who are eligible for ACT to remain on the waitlist.

(2) No Member on a waitlist for ACT services shall be without such services for more than thirty (30) days.

d. ~~(6)~~ For Members with Severe and Persistent Mental Illness (SPMI), Contractor shall ensure that:

(1) ~~(a)~~ ~~Members with SPMI~~ are assessed to determine eligibility for ACT.

(2) ~~(b)~~ ACT services are provided ~~for all adult Members with SPMI who are referred to and eligible for ACT services~~ in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255.

(3) ~~(e)~~ Additional ACT capacity is created ~~to serve adult Members with SPMI within Contractor's Service Area~~ as services are needed in accordance with OAR 410-141-3220.

~~(7)~~ ~~When ten (10) or more of Contractor's adult Members with SPMI in Contractor's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Contractor solutions, additional capacity shall be created by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams.~~

~~(8) If Contractor lacks qualified providers to provide ACT services, Contractor shall consult with OHA and develop a plan to develop additional qualified providers. Lack of capacity shall not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist. No individual on a waitlist for ACT services should be without such services for more than 30 days.~~

- e. ~~(9) Contractor shall ensure all denials of ACT services for all adult Members with SPMI are:~~
- ~~(1) (a) Based on established, evidence-based~~Evidence-Based medical necessity criteria;
 - ~~(2) (b) Recorded and compiled in a manner that allows denials to be accurately reported out as appropriate~~Medically Appropriate or inappropriate; ~~and~~
 - ~~(3) (c) Follow the Notice of Adverse Benefit Determination process for all denials as described in Exhibit B, XX~~accordance with the applicable sections of Ex. I of this Contract.
- ~~(10) For Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards, Contractor shall be responsible for finding or creating a team to serve the Member.~~
- ~~(11) Contractor shall report number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month.~~
- ~~(12) Contractor shall ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative.~~
- ~~(13) Contractor shall ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs.~~
- f. Contractor shall provide, to OHA via Administrative Notice, any and all documentation related to ACT obligations set forth in this Sec. 8 of Ex. M within five (5) Business Days of request by OHA

9. e. Peer Delivered Services:

- a. ~~(1) Contractor shall inform Members of and encourage utilization of Peer Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a, including Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs, or other Peer Specialist, in accordance with OAR 309-019-0105.~~
- b. ~~(2) Information provided~~Contractor shall encourage utilization of PDS by providing Members with information, which must include a description of ~~Peer Delivered Services~~PDS and how to access it, a description of the types of PDS ~~providers~~Providers, an explanation of the role of the PDS ~~provider~~Provider, and ways that PDS can enhance ~~a Member~~Members's care.
- ~~(3) Contractor shall provide access to Peer-Delivered Services for each Member seeking these services consistent with OAR 309-019-0105.~~
- c. ~~(4) Contractor may utilize Peer-Delivered Services~~PDS in providing other Behavioral Health services such as ACT, ~~Crisis~~crisis services, Warm Handoffs from ~~hospitals~~Hospitals, and services at Oregon State Hospital.

~~f.~~ **~~Supported Employment~~**

- ~~(1) Contractor shall ensure access to supported employment services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295.~~
- ~~(2) Contractor shall report number of individuals referred to Supported Employment (SE), number of individuals receiving SE, number of individuals receiving SE that are employed in Competitive Integrated Employment.~~

~~g.~~ **~~Crisis, Urgent, and Emergency Services~~**

10. Behavioral Health Crisis Management System:

- a.** ~~(1) Contractor shall establish written policies and procedures and monitoring systems for an emergency response~~a crisis management system, including ~~post-stabilization care services~~Post Stabilization Services and Urgent Care Services available for all Members on a twenty-four (24)-hour, seven (7)-day-a-week basis consistent with OAR 410-141-3140 ~~and~~, 42 CFR 438.114~~-, and the applicable section of Ex. B, Part 2 of this Contract.~~
- b.** The ~~emergency response~~crisis management system must provide an immediate, initial ~~or~~and limited duration response for ~~emergency situations or~~ potential Behavioral Health emergency situations or emergency situations that may include Behavioral Health conditions, including:
- (1)** ~~(a)~~ Screening to determine the nature of the situation and the Member's immediate need for Covered Services;
- (2)** ~~(b)~~ Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing ~~the~~a crisis situation;
- (3)** ~~(c)~~ Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
- (4)** ~~(d)~~ Provision of Covered Services and ~~outreach~~Outreach needed to address the urgent or ~~emergency~~crisis situation; and
- (5)** ~~(e)~~ Linkage with ~~the~~ public sector crisis services, such as ~~pre-commitment~~Mobile Crisis Services and diversion services.
- c.** The crisis management system must include the necessary array of services to respond to Behavioral 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.
- d.** ~~(2) Contractor shall ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, 309-019-0243 and 309-019-0300 to 309-019-0320 to promote stabilization in a community~~Community setting rather than arrest, presentation to an ~~emergency department~~Emergency Department, or admission to an ~~acute psychiatric~~Acute care facility.
- ~~(3)~~
- e.** Contractor shall establish a written ~~policies and procedures for a quality improvement~~Quality Improvement plan for the ~~emergency response system.~~
- ~~(4) 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/respice and short term stabilization unit capabilities.~~

- ~~(5) 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.~~

~~h. Non-covered Services~~

- ~~(1) 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.~~
- ~~(2) Contractor shall provide non-health related services, supports and activities that can be expected to improve a Member's Behavioral Health condition including flexible funding as defined by the SOCWI guidance document link found in Exhibit B, part 2(4)(m)(1).~~

~~i. Prior Authorization~~

- ~~(1) Notwithstanding the requirements outlined in Exhibit B Part 2, 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, behavioral or oral health condition or disease in accordance with 42-CFR §438.210.~~
- ~~(2) Contractor shall establish written policies and procedures for prior authorizations that are compliant with Mental Health Parity regulations in 42-CFR part 438, subpart K.~~
- ~~(3) Contractor shall monitor prior authorizations and must report an accurate number of approvals and denials to OHA, upon request.~~
- ~~(4) Contractor shall not require prior authorization for outpatient Behavioral Health services or Behavioral Health peer delivered services.~~
- ~~(5) Any non-emergent prior authorization for hospitalization and residential care shall be approved within three days for children, youth or adult members.~~

- ~~(6) — The prior authorization for any service and the length of any prior authorization shall be based on an evidence-based standard of medical necessity.~~
- ~~(7) — Prior authorized services shall be reviewed for consistency of medical necessity application, using a standardized methodology such as inter-rater reliability, with a concordance rate that is equal to or more favorable than the standard applied to medical/surgical services.~~
- ~~(8) — Denials of prior authorized services shall be made by a professional peer, a person with the clinical scope of practice to order the service being requested, crisis managementsystem to address the requirements identified in OAR 410-141-3140, and provide the Quality Improvement plan to OHA upon request.~~

11. Care Coordination / Intensive Care Coordination:

- a. ~~(9) Contractor shall also ensure that any treatment limitations placed on Medically Necessary Covered Services are no more restrictive than those applied to fee for service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i).~~
- ~~(10) — 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.~~
- ~~(11) — Contractor may not require Members to obtain the approval of a Primary Care Physician in order to gain access to behavioral health Assessment and Evaluation services. Members may refer themselves to behavioral health services available from the Provider Network.~~
- ~~(12) — 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.~~
- ~~(13) — For standard Service Authorization Requests, Contractor shall provide notice to the requesting provider as expeditiously as the Member's health or behavioral health condition requires, not to exceed 14 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.~~
- ~~(14) — 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, or if an CCO denies a service authorization request, or decides to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall issue a notice of adverse benefit determination to the Provider and Member, or Member Representative, consistent with Exhibit I, Grievance System.~~
- ~~(15) — 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, and provide Notice, as expeditiously as the member's health or behavioral health condition requires and no later than 72 hours after receipt of the request~~

~~for service. Contractor may extend the 72 hour 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.~~

~~(16) 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.~~

~~(17) 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.~~

~~3. Care Coordination and Integration~~

~~a. Care Coordination~~

~~(1) Contractor shall provide Care Coordination~~ provide Care Coordination and Intensive Care Coordination for Members with Behavioral Health disorders in accordance with ~~Exhibit B in~~OAR 410-141-3160, 410-141-3165, and 410-141-3170 and the applicable sections in Ex. B, Parts 2 and 4 of this Contract.

~~b. (2) Contractor shall ensure all care coordinators~~Care Coordinators work with Provider team members to coordinate integrated care. This includes but is not limited to coordination of: physical health, ~~behavioral health~~Behavioral Health, intellectual and developmental disability, DHS, ~~OYA, social determinants~~Oregon Youth Authority, Social Determinants of ~~health~~Health, and ~~ancillary services~~Ancillary Services.

~~c. (3) Contractor must abide by OAR 410-141-3160/3170 in regards to care integration and interdisciplinary team requirements for members receiving ICC~~shall ensure coordination and appropriate Referral to ICC to ensure that Member's rights are met and there is post-discharge support.

~~(4) Contractor shall ensure sufficient resources, including technological, financial, provider and workforce, to integrate Behavioral Health services with oral and physical health care.~~

~~(5) Contractor shall provide oversight, care coordination, transition planning and management of the Behavioral Health needs of Members to ensure culturally responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in the most natural and integrated environment possible and that minimizes the use of institutional care. Contractor shall follow ICC standards as identified in OAR 410-141-3160/3170.~~

~~d. Contractor shall authorize and reimburse for ICC services, in accordance with OAR 410-141-3160 and 410-141-3170.~~

~~e. Contractor shall track and coordinate for ICC reassessment triggers and ensure there are multiple rescreening points for Members based on reassessment triggers for ICC~~

12. Community Mental Health Program:

~~a. (6) Contractor shall enter into a written memorandum of understanding (MOU) agreement with the local community mental health program (CMHP)~~Local Mental Health Authority in Contractor's ~~service area~~Service Area by January 1, 2020.

~~The MOU shall include:~~

- ~~(a) — A formalized agreement that the Contractor will coordinate with the CMHP on the development of a comprehensive Behavioral Health Plan for Contractor's service area; and~~
- ~~(b) — All the requirements identified in in accordance with ORS 414.153.(7). The agreement shall require Contractor shall:~~
- (1) To develop a comprehensive Behavioral Health plan for Contractor's ~~service area~~Service Area in collaboration with the ~~local mental health authority~~Local Mental Health Authority and other ~~community~~Community partners (e.g., education/schools, ~~hospitals~~Hospitals, corrections, police, first responders, ~~child welfare~~Child Welfare, DHS, public health, ~~peers~~, families, housing authorities, housing providers, courts); ~~and~~
- ~~(8) — Contractor shall ensure that periodic social-emotional screening for all children birth-through five years is conducted in the primary care setting and shall have a process in place to address any concerns revealed by the screening in a timely manner.~~
- ~~(9) — Contractor shall support providers in screening all (universal screening) pregnant women for behavioral health needs (mental health and substance use), at least once during pregnancy and post-partum. Contractor shall ensure medically appropriate follow-up and referral as indicated by screening. Contractor shall ensure and provide timely appropriate referrals, and follow-up to referrals for pregnant and post-partum women.~~
- ~~(10) — Contractor shall ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate behavioral health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment~~
- ~~(11) — Contractor shall execute the work and milestones outlined in Contractor's MOU with the CMHP.~~
- ~~(12) — Contractor shall work collaboratively with OHA and CMHPs to develop and implement plans to better meet the needs of Members in less institutional community settings and to reduce recidivism to emergency departments for Behavioral Health reasons.~~
- ~~(13) — Contractor shall work collaboratively with other providers in the health care continuum to improve services for adult Members with SPMI.~~
- (2) (14) Contractor shall To coordinate and collaborate on the development of the ~~community health improvement plan (CHP) under ORS 414.627~~Community Health Improvement Plan with the local ~~community mental health program (CMHP)~~ for the delivery of mental health services ~~under~~in accordance with ORS 430.630.
- ~~(15) — Contractor shall work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a community placement in the most integrated setting appropriate for that person. Discharge shall be to housing consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. The individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated in light of cost, availability, and the other factors stated above.~~
- ~~(16) — Contractor shall work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism.~~

~~(17) Contractor will work with local jurisdictions to share information with jails regarding the Behavioral Health diagnosis, status, medication regimen, and services of Members who are incarcerated.~~

13. b. Oregon State Hospital :

- a. ~~(1) Contractor will assume increasing accountability for Members who are civilly committed and are referred to and enter Oregon State Hospital.~~
- ~~(2) Contractor will~~shall be financially responsible for Members on the waitlist for ~~Oregon State Hospital after OSH beginning in~~ Contract Year ~~2021, with a timeline to be determined by OHA~~2022.
- b. ~~(3) Contractors will be financially responsible and begin to~~ Contractor shall share financial risk for services for Members in OSH ~~after contract year 2021, with a timeline to be determined by OHA beginning in~~ Contract Year 2022.
- c. ~~(4) Contractor shall, in accordance with OAR 309-091-0000 through~~ 309-091-0050:
- (1) ~~(a) Coordinate with applicable subcontractors~~Subcontractors as needed regarding ~~Oregon State Hospital~~ discharges for all adult Members with SPMI;
- (2) ~~(b) Coordinate care for members receiving behavioral health treatment while admitted to the State hospital~~Members during discharge planning for the return to Home ~~CCO Contractor~~ or to the ~~receiving CCO~~Receiving Contractor if ~~the~~ Member will be ~~discharging~~discharged into a different ~~CCO~~Service Area when ~~the patient~~Member has been deemed ready to transition;
- (3) ~~(c) Arrange for both physical and behavioral health care services coordination~~Behavioral Health care Services Care Coordination;
- (4) ~~(d) Provide case management, care coordination~~Case Management Services, Care Coordination and discharge planning for timely follow up to ensure ~~continuity~~Continuity of ~~care~~Care;
- (5) ~~(e) Coordinate with OHA regarding members~~Members who are presumptively or will be retroactively enrolled in Oregon Health Plan upon discharge;
- (6) ~~(f) Arrange for all services to be provided post-discharge in a timely manner; and~~
- (7) ~~(g) Provide access to evidence-based~~Evidence-Based intensive services for adult Members with SPMI discharged from ~~Oregon State Hospital who~~OSH who refuse ACT services.
- d. ~~(5) Discharges from OSH shall not be to a secure residential treatment facility unless clinically necessary~~Medically Appropriate. No ~~one~~Member shall be discharged to a secure residential treatment facility without the ~~express~~expressed prior written approval of the Director of OHA or ~~his/her~~the Director's designee.
- e. Contractor shall ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet Member's needs.

14. e. Emergency Department Utilization:

- a. Contractor's Behavioral Health services must address the following key areas:
- (1) Reduce visits to Emergency Departments.

- (2) Reduce repeat visits to Emergency Departments.
- (3) Reduce the length of time Members spend in Emergency Departments.
- (4) Ensure Members are contacted and offered services to prevent utilization of Emergency Departments.
- (5) Ensure Members with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit from Intensive Care Coordinator or other relevant Provider within three (3) days.

- b. ~~(1)~~ Contractor shall ~~establish a policy and procedure for the development and implementation of~~ develop and implement an individualized management plan for ~~contacting and offering services to each~~ a Member who has two (2) or more ~~readmissions visits~~ to an Emergency Department ~~in~~ within a six ~~(6)~~-month period. ~~The management plan will address the following key areas:~~
 - ~~(a) — Reduce admissions to emergency departments.~~
 - ~~(b) — Reduce readmissions to emergency departments.~~
 - ~~(c) — Reduce the length of time Members spend in emergency departments.~~
 - ~~(d) — Ensure Members with SPMI have appropriate connection to community-based services after leaving an emergency department and will have a follow-up visit from Intensive Care Coordinator or other relevant provider within 3 (three) days.~~

- c. ~~(2)~~ Contractor shall work with ~~hospitals~~Hospitals to ~~provide~~obtain data on Emergency Department ~~(ED)~~ utilization for Behavioral Health reasons and length of time in the ED. Contractor shall develop remediation plans with ~~EDs~~Hospitals with significant numbers of ED stays longer than 23 hours.

- d. ~~(3)~~ Contractor shall work with ~~hospitals~~Hospitals on strategies to reduce ED utilization by Members with Behavioral Health disorders.

- e. Contractor shall work collaboratively with OHA and CMHPs to develop and implement plans to better meet the needs of Members in less institutional Community settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons.

15. d. Involuntary Psychiatric Care:

- a. ~~(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.
- b. ~~(2)~~ Contractor shall ~~establish written policies and procedures describing~~employ the ~~appropriate use of~~ Emergency Psychiatric Holds consistent with ORS ~~426~~426.130 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.
- c. ~~(3)~~ Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340.

- d.** ~~(4)~~ Contractor shall comply with ORS Chapter 426 and OAR 309-091-0000 through 309-091-0050 for involuntary Civil Commitment of those Members who are civilly committed under ORS 426.130.
- e.** ~~(5)~~ Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with ~~administrative rule and statute~~ORS Chapter 426 and OAR 309-091-0000 through 309-091-0050 and shall coordinate with the CMHP Director in the Contractor's Service Area in assuring that all ~~statutory~~legal 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.
- f.** Contractor shall work with secure residential treatment facilities to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting appropriate for that person. Discharge shall be to housing consistent with the Member's treatment goals, clinical needs, and informed choice. The Member's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably and medically accommodated in light of cost, availability, and the other factors stated above.

16. ~~e.~~ Long Term Psychiatric Care (LTPC):

- a.** Contractor will be financially responsible for LTPC benefit for Members after Contract Year 2021, with a timeline to be determined by OHA.
- b.** ~~(1)~~ For a Member age 18 or older:
 - (1)** ~~(a)~~ If Contractor identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, ~~acute~~Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the applicable ~~HSD~~Health Services Division, Adult Mental Health Services Unit, as described in ~~Procedure~~the procedure for LTPC Determinations for Members 18 to 64, available on the CCO Contract Reports-Web-Site~~Forms Website~~.
 - (a)** ~~i.~~ HSD Adult Mental Health Services Unit will respond to Contractor no more than three (3) Business Days following the date HSD receives a completed Request for LTPC Determination for Member 18-64.
 - (2)** ~~(b)~~ If Contractor identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, Contractor shall request a LTPC determination from the Oregon State ~~hospital~~Hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the CCO Contract Reports-Web-Site~~Forms Website~~.
 - (a)** ~~i.~~ OCS Team will respond to Contractor no more than three (3) Business Days following the date the OCS Team receives a completed Request for LTPC Determination for Member Requiring Neuropsychiatric Treatment.
 - (3)** ~~(e)~~ A Member is appropriate for LTPC when ~~the~~ :
 - (a)** 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~~

- (b)** 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.
- (4)** ~~(d)~~ 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, until such time that OHA transfers this financial responsibility to Contractor.
- (5)** ~~(e)~~ If a Member is ultimately determined appropriate for LTPC, the effective date of such determination ~~is either~~will be any one of the following:
- (a)** ~~i.~~ Within three (3) Business Days of the date HSD Adult Mental Health Services Unit staff receives a completed Request for LTPC Determination for Persons ~~Age~~age 18 to 64;
- (b)** ~~ii.~~ The date the State Facility -NTS OCS Team receives a completed Request for LTPC Determination for Persons Requiring State ~~hospital~~Hospital-NTS;
- (c)** ~~iii.~~ In cases where OHA and Contractor mutually agree on a date other than ~~these dates as identified in (A) or (B) above~~, the date mutually agreed upon; or
- (d)** ~~iv.~~ In cases where the Clinical Reviewer determines a date other than a date described above, the date determined by the Clinical Reviewer.
- (6)** ~~(f)~~ In the event Contractor and HSD Adult Mental Health Services Unit staff disagrees about whether a Member 18 to 64 is appropriate for LTPC, Contractor may request, within three (3) 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 (e)~~in subpara. v. of this Sec. 37.b. The cost of the clinical review will be divided equally between Contractor and OHA.
- (7)** ~~(g)~~ Contractor shall work with the appropriate OHA Team or designee in managing admissions, discharges and transitions from LTPC for Members who require ~~such care~~LTPC at a State Facility, to ensure that Members are served in and transition into the most appropriate, independent, and integrated ~~community~~Community-based setting possible.
- (8)** ~~(h)~~ For Members, 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~~Community-based setting possible consistent with Member choice.
- b.** ~~(2)~~ For a Member age seventeen (17) or younger:
- (1)** ~~(a)~~ If Contractor identifies a Member who is age seventeen (17) or younger is appropriate for LTPC ~~referral~~Referral, Contractor shall request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in

Procedure for LTPC Determinations for Members 17 and Under, available on the [CCO Contract Reports Web Site](#)~~Forms Website~~;

- ~~(2)~~ ~~(b)~~ The HSD Child and Adolescent Mental Health Specialist will respond to Contractor no more than seven ~~(7)~~ Business Days following the date HSD receives a completed Request for LTPC Determination for Member 17 and Under.
- ~~(3)~~ ~~(e)~~ Contractor shall work with the HSD Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC ~~(SCIP and SAIP)~~Secure Children's Inpatient Program and Secure Adolescent Inpatient Program.
- ~~(4)~~ ~~(d)~~ The Member will remain enrolled with the Contractor for delivery of SCIP and SAIP services. Contractor shall ~~bear care coordination responsibility~~be responsible for Care Coordination for the entire length of stay, including admission determination and planning, linking the Child and Family Team and Intensive Outpatient Services and Supports ~~(IOSS)~~ Provider, services provided by LTPC service ~~provider~~Provider and transition and discharge planning. This should include collaborative relationships with all system partners to achieve ~~continuity~~Continuity of ~~care~~Care. Contractor shall ensure that utilization of LTPC is reserved for the most Acute and complex cases and only for ~~a~~the period of time necessary and Medically Appropriate to remediate symptoms that led to admission.
- ~~(5)~~ ~~(e)~~ For the Member and the parent or guardian of the Member, the ~~care coordinator~~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.

17. ~~f.~~ **Acute Inpatient Hospital Psychiatric Care:**

- ~~(1)~~ ~~Contractor will be financially responsible for mental health residential benefit for Members after Contract Year 2021, with a timeline to be determined by OHA.~~
- a. ~~(2)~~ Contractor shall provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC and for whom it is ~~medically indicated~~Medically Appropriate.
- b. Contractor shall submit required data through the ~~Oregon Patient/Resident Acute Care System (OPRCS)~~reporting database as instructed by OHA.
- c. ~~(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~~Member 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.
- d. ~~(4)~~ Contractor shall ~~establish a policy and procedure for the development and implementation of~~develop and implement a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period. ~~The management plan will address subsections (5)-(10) in this section.~~
- e. ~~(5)~~ Contractor shall ensure all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a ~~community~~Community case manager, ~~peer bridger~~Peer, or other ~~community provider~~Community Provider prior to discharge, and that all such Warm Handoffs are documented.

- f.** ~~(6)~~ Contractor shall ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate ~~behavioral~~Behavioral Health and primary health care in the ~~community~~Community prior to discharge and that all such linkages are documented, in accordance with OAR ~~provisions~~ 309-032-0850 through 309-032-0870.
- g.** ~~(7)~~ Contractor shall ensure all adult Members receive a follow-up visit with a ~~community~~Community Behavioral Health ~~provider~~Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital, or ~~three~~ (3) days if Member is involved in Intensive Care Coordination services.
- ~~(8) — Contractor shall reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals.—~~
- h.** ~~(9)~~ Contractor shall coordinate with system ~~community~~Community partners to ensure Members who are ~~homeless~~Homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated setting, consistent with the ~~individual~~Member's treatment goals, clinical needs and ~~the individual's~~ informed choice.
- i.** ~~(10)~~ Contractor shall work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and shall work with Acute Care Psychiatric Hospitals in the development of each individual's housing ~~assessment~~Assessment. The housing ~~assessment~~Assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the ~~individual~~Member's treatment goals, clinical needs, and ~~the individual's~~ informed choice. Contractor shall notify, or require the Acute Care Psychiatric Hospital to notify, the ~~community provider~~Community Provider to facilitate the implementation of the plan for housing.
- g.** — ~~Psychiatric Residential Treatment Services and Psychiatric Day Treatment Services (PRTS /PDTs)~~
- ~~(1) — Contractor shall adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTs) and/or intensive outpatient services and supports.—~~
- ~~(2) — Contractor shall ensure that admission to Psychiatric Residential Treatment Services are in accordance with Certificate of Need process described in OAR 410-172-0690 and conducted through a OHA approved independent reviewer.—~~
- ~~(3) — Services and supports shall be authorized to meet the needs of the child or youth which address the recommendations stated in the mental health assessment.~~
- ~~(a) — Referrals shall be reviewed within 3 days.~~
- ~~(b) — 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.—~~
- ~~(c) — If Contractor denies a service, a medically appropriate plan of care shall be developed to address the Behavioral Health needs of the Member.—~~
- h.** — ~~Intensive Care Coordination~~

18. Women's Health:

- a.** ~~(1) Contractor shall authorize and reimburse care coordination services, in particular Members who receive ICC, 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.~~ ensure Members receiving prenatal and post-partum care are screened using validated tools for Behavioral Health needs at least once during pregnancy and post-partum, and ensure Medically Appropriate follow-up and Referral as indicated by screening.
- ~~(2) Contractor shall authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160/3170.~~
- ~~(3) Contractor shall ensure coordination and appropriate referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support. If Member is connected to ICC coordinator, Contractor shall ensure coordination is in accordance with the requirements outlined in OAR 410-141-3160/3170.~~
- ~~(4) Contractor shall ensure that Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs. Housing should be consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. The individual's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably accommodated, in light of cost, availability, and the other factors stated above. Among housing types, where available and appropriate, Supported Housing is the most integrated and preferred option.~~
- ~~(5) Contractor shall ensure there are multiple rescreening points for Members based on reassessment triggers for ICC.~~
- ~~(6) Contractor shall adopt policies and procedures to track and coordinate for ICC reassessment triggers.~~
- ~~(7) Members who receive Intensive Care Coordination (ICC) services must have the option to have ICC support in continuity of care throughout episodes of care for all care coordination needs as identified in OAR 410-141-3160/3170.~~
- ~~(8) Contractor shall arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition.~~

i. ~~Transition/Discharge~~

- ~~(1) Contractor shall provide oversight, care coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and community based settings.~~
- ~~(2) Contractor shall ensure that members transitioning to another healthcare setting are placed consistent with the individual's treatment goals, clinical needs, and the individual's informed choice. Contractor shall follow ICC standards as identified in OAR 410-141-3160/3170.~~
- ~~(3) Contractor shall provide Utilization Review and utilization management, for Members receiving Mental Health Rehabilitative Services and Personal Care Services in licensed and non-licensed home and community based settings, ensuring that individuals who no~~

~~longer need placement in such setting are transition to a community placement in the most integrated setting appropriate for that person.~~

- ~~(4) Contractor shall ensure continuity of care at all times, over all episodes and levels of care.~~
- ~~(5) The intensive care coordinator assigned by the Contractor shall have contact with active program specific care team(s), at least twice per month for general coordination, or sooner if clinically necessary for Member's care.~~
- ~~(6) Contractor shall maintain responsibility for providing Behavioral Health services if a Member needs services which are out of the Contractor's service area due to lack of local availability.~~
- ~~(7) The intensive care coordinator shall work with any provider to ensure a smooth transition between service areas and episodes of care.~~
- ~~(8) The assigned intensive care coordinator shall participate and play an active role in discharge planning for Member.~~
 - ~~(a) The care coordinator shall have contact with the Member no less than 2 times per month prior to discharge and 2 times within the week of discharge.~~
 - ~~(b) Contractor shall ensure a face to face Warm Handoff for Member between any care coordinator and other relevant care provider during transition of care and discharge planning.~~
 - ~~(c) Care coordinators (including ICC, if appropriate) shall also engage with the Member, face to face, within 3 days post discharge.~~
 - ~~(d) Contractor shall require a transition meeting and development of a transition plan that includes a description of how treatment and supports will continue. This meeting shall be held 30 days prior to discharge or as soon as possible, no later than within one week of discharge, if notified of impending transition with less than 30 days lead time.~~
 - ~~(e) Contractor shall require a post transition meeting of Interdisciplinary Team for members requiring ICC, within 14 days, to ensure care was continued and quickly address any gaps.~~

b. ~~(f) Contractor shall ensure members maintain access to appropriate services continue after discharge~~pregnant women receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3220.

~~(9) Contractor shall report on the number of Warm Handoffs that occur.~~

19. ~~4.~~ Children and Youth Behavioral Health Services

~~a.~~ **Provision of Services**

20. :

a. ~~(1)~~ Contractor shall provide services to children, young adults and families ~~of~~that are sufficient in 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 Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder.

- b.** Contractor shall ensure women with children, unpaid caregivers, families and children ages birth through five (5) years, receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3220.
- c.** ~~(2)~~ 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~~becoming Homeless or other undesirable outcomes due a Behavioral Health disorder.
- ~~(3) — Children and youth shall not be required to participate in Wraparound services in order to access Intensive Treatment Services (ITS) or Intensive Care Coordination (ICC).~~
- d.** ~~(4)~~ Contractor shall utilize ~~evidence-based~~Evidence-Based Behavioral Health interventions for the ~~behavioral health~~Behavioral Health needs of ~~members~~Members who are children and youth.
- e.** ~~(5)~~ Contractor shall ensure Members have access to ~~evidence-based—dyadic treatment~~Evidence-Based Dyadic Treatment and treatment that allows children to remain living with their primary parent or guardian.
- ~~(6) — Contractor shall provide care coordination or Intensive Care Coordination (ICC), as appropriate, that is family and youth driven, strengths based, culturally responsive and linguistically appropriate.~~
- f.** Contractor shall ensure that children in the highest levels of care (subacute, residential or day treatment) continue Dyadic Treatment with their caregivers whenever possible, and have a full psychological evaluation and child psychiatric consultation.
- g.** ~~(7)~~ Contractor shall ensure ICC is ~~provided~~available, at a minimum, for Members ~~seventeen (17)~~ and younger for any of the following situations, ~~or any other population entitled to ICC services~~ in accordance with OAR 410-141-3160/, OAR 410-141-3165 and 410-141-3170:
- ~~(a) — Children and youth engaged in Behavioral Health services that have two or more placement disruptions due to emotional and/or behavioral precipitators in less than one year.~~
- (1)** ~~(b)~~ Children and youth placed in a correctional facility solely for the purpose of stabilizing a Behavioral Health condition.
- (2)** ~~(c)~~ Children and youth placed out of the Contractor's Service Area in behavior rehabilitation service ~~area in Behavior Rehabilitation Services~~ programs under the jurisdiction of ~~child welfare~~Child Welfare.
- (3)** ~~(d)~~ Children and youth, known to be receiving or to have received care in an Emergency Department, or admission to Acute Inpatient Psychiatric Care and/or ~~Sub-Acute Care~~sub-acute care or upon discharge from such care
- h.** ~~(8)~~ ~~Contractor~~Contractor shall coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members ~~seventeen (17)~~ and under, including Members in the care and custody of DHS Child Welfare or Oregon Youth Authority (OYA). For a Member ~~seventeen (17)~~ and under, placed by DHS Child Welfare through a ~~Voluntary Placement Agreement~~voluntary placement agreement (CF 0499), Contractor shall also coordinate with such Member's parent or legal guardian.

~~b.~~ **Wraparound Services**

i. Contractor shall ensure that admission to PRTS is in accordance with Certificate of Need process described in OAR 410-172-0690 and conducted through a OHA-approved independent reviewer.

j. Contractor shall ensure that level of care criteria for Behavioral Health outpatient services and Intensive Outpatient Services and Supports include children birth through five (5) years in accordance with OAR Chapter 309, Division 22.

(1) Contractor shall ~~complete~~require a ~~plan for serving eligible youth in Wraparound so that no youth is placed on a waitlist. This strategy shall ensure there is no waitlist for youth who meet criteria. This strategy shall ensure that contractor has the ability to implement Wraparound to fidelity~~minimum level of intensive outpatient level of care for children birth through five (5) years with indications of Adverse Childhood Events and high complexity due to one or more of the following: multi system involvement, two or more caregiver placements within the past six (6) months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement.

~~(2)~~

k. Contractor shall ensure that ~~Wraparound services and supports include Family Support Specialist, (Family Partners) and Young Adult Support Specialists (Youth Partners), as appropriate.~~

~~(3) Contractor shall ensure that Family Support Specialists and Young Adult Support Specialists have experience navigating the Behavioral Health, child welfare, or juvenile justice system with a child or youth, and be active participants in the Wraparound process, and that family support specialists engage and collaborate with systems alongside the family, parent, or guardian. Contractor shall refer to the System of Care guidance document in Exhibit B Part 2 on expectations for Family Support Specialists and Young Adult Support Specialists. periodic social-emotional screening for all children birth through five (5) years is conducted in the primary care setting and ensure any concerns revealed by the screening are addressed in a timely manner.~~

l. Wraparound Services: Contractor shall provide Wraparound services and supports to eligible Members in accordance with OAR 309-019-0325 and 309-019-0326.

(1) ~~(4)~~ Contractor shall ~~establish~~develop and maintain a written Wraparound policy, which includes:

(a) ~~The services~~Services and supports a Child and Family Team can select and which services and supports need prior approval of the Providers; and

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

n. ~~(5)~~ Contractor shall submit the Wraparound policy or revisions to the Wraparound policy ~~annually that have been approved by its System of Care Executive Council~~ to OHA for review and approval, no later than January 31, ~~2020~~. ~~In the event that have been approved by its System of Care Executive Council, OHA does not approve them, Contractor must follow the process set forth in Ex. D, Sec. 5 to the OHA this Contract Administration Unit for review and approval.~~

- (1) OHA will notify Contractor within thirty (30) days of the approval status of the policy. Subsequent submissions will be upon OHA request.
- (2) ~~(6)~~ Contractor shall maintain sufficient funding and resources to implement Wraparound Care Coordination Services to ~~fidelity~~Fidelity for Members ~~seventeen (17)~~ years 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 (PRTS) or the Commercial Sexually Exploited Children's residential program funded by OHA; and
 - (c) Children meeting local/regional Wraparound Initiative entry criteria.
- (3) ~~(7)~~ Contractor shall ~~enroll all eligible youth in Wraparound and place no youth on a waitlist.~~
- ~~(8) Contractor shall ensure that core values and principles described in ORS 418.977 are followed in delivering Wraparound services and supports, Wraparound Care Coordination and Team Facilitation.~~
- ~~(9) Contractor shall ensure that every youth in Wraparound receives a Child and Adolescent Needs and Strengths (CANS) screening within 30 days of enrollment and every 90 days thereafter.~~
- ~~(10) For Wraparound services, Contractor shall ensure that the ratio of care coordinators, family support specialists, and youth support specialists to families served is no greater than 1:15.~~
- ~~(11) Upon discharge from a Wraparound program, Contractor shall ensure that Member is re-screened and assessed for Intensive Care Coordination needs, as identified in OAR 410-141-3160-70.~~

~~e.~~ **Wraparound Review Committee**

- ~~(1) Contractor shall convene and maintain a Wraparound Review Committee which shall review all referrals submitted to the Wraparound program and determine eligibility for entry into the program in accordance with OAR 309-019-0325.~~
- ~~(2) Contractor shall submit any consistently identified Wraparound or system barriers to the System of Care Practice Level Workgroup up through the Executive Council if needed and submit barriers that remain unresolved to the State System of Care Steering Committee. These workgroups and councils are further defined in the contract under the System of Care, in 6. Of this section.~~
- ~~(3) Contractor shall screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at: <http://www.oregon.gov/oha/hsd/amh/pages/index.aspx>.~~
- (4) Contractor shall screen and provide services to no fewer than XXX Members per month.
- (5) (4) Contractor shall ensure the implementation of fidelityFidelity Wraparound by ~~hiring and ensuring that each role is trained in Fidelity~~requiring Wraparound.

- ~~(5)~~ ~~Contractor shall~~ Providers to hire and train the following staff:
- (a) Wraparound Care Coordinator;
 - (b) Wraparound ~~Supervisor~~supervisor;
 - (c) Wraparound Coach;
 - (d) Youth Peer Delivered Service Provider;
 - (e) Family Peer Delivered Service Provider; and
 - (f) Peer Delivered Service Provider ~~Supervisors~~supervisors.
- (6) Contractor shall ~~complete the Wraparound Fidelity Index Short Form (WFI-EZ) for each youth and caregiver enrolled in Wraparound after six months of being enrolled in~~ensure Providers (including Day Treatment, PRTS, SAIP and SCIP Providers) are trained in Wraparound values and principles and the Provider's role within the Wraparound child and Family Team.
- ~~(7) Contractor shall utilize WFI-EZ Report 8 to identify specific focus areas for improvement in WrapTrack. These items shall be the target of ongoing program improvement and scores shall be monitored over time for progress. The report 8 shall be shared with SOC Advisory Council no less than four times per year. A minimum of 35 percent response rate of youth enrolled is needed for statistical significance.~~
- ~~(8) Contractor shall work with OHA identified technical assistance entities to ensure the implementation and sustainability of SOC values, principles and governance structures, Fidelity Wraparound practice and youth and family partnerships. Contractor shall follow guidelines in the Oregon Best Practice Guide, as described at this location: <https://www.pdx.edu/ccf/best-practice-guide>.~~
- ~~(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 at the following website: <https://depts.washington.edu/wrapeval/content/quality-assurance-and-fidelity-monitoring>.~~
- ~~(10) Contractor shall work with OHA identified technical assistance entities to administer a tool to identify, implement and measure Fidelity of its Wraparound services and supports to ensure that Team Facilitation and Wraparound Care Coordination are consistent with SOC values and are culturally relevant as described at at the following website: <https://gucchd.georgetown.edu/products/SOCIssueBrief.pdf>~~

~~d.~~ **System of Care (SOC)**

~~Coordination with child and family serving entities is necessary to ensure quality of care, family and young adult satisfaction and positive outcomes.~~

- o. ~~(1)~~ System of Care: Contractor shall develop and implement cost-effective comprehensive, person-centered, individualized, and integrated community-based Child and Youth Behavioral Health services for Members, using ~~System~~ of Care (SOC) principles.

- (1) ~~(2)~~ Contractor shall establish and maintain a functional System of Care in its ~~service area in accordance with the Best Practice Guide located at~~ <https://www.pdx.edu/ccf/best-practice-guide-includingServiceArea>.

- (2) Contractor shall have a functional SOC governance structure by the beginning of CY 2020, except a Contractor with a new Service Area shall have a functional SOC governance structure for that Service Area by July 1, 2020.
- (a) The SOC governance structure shall consist of a Practice Level Workgroup, Advisory Committee, and Executive Council with a goal of youth and family voice representation to be fifty-one (51) percent.
- (b) As long as the functions are carried out in Rural and Frontier areas, up to two System of Care Councils may be combined. Contractor ~~shall~~must work with any ~~other CCO~~and all Contractors within the same ~~region~~Service Area (if applicable) to ensure a singular, collaborative System of Care structure for the ~~region~~Service Area.
- ~~(3) Contractor shall have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council.~~
- (c) ~~(a)~~The Practice Level Workgroup shall review Wraparound practice barriers, remove barriers when possible, and submit barriers that remain unresolved to the SOC Advisory Committee and/or Executive Council for resolution and/or advancement to the State System of Care Steering Committee.
- (d) ~~(b)~~The Practice Level Workgroup ~~consists~~must consist of representatives of ~~the Contractor, its providers, Providers, local public~~ child serving agencies ~~and other agencies including, young adults and Youth Adult Peer Support, families and Family partners, and advocacy organizations and reflective of local culture~~(Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) and must include meaningful participation from youth and family members.
- (e) ~~(c)~~The Advisory Committee shall advise on policy development, implementation, ~~reviews fidelity~~review Fidelity and outcomes, and ~~provides~~provide oversight using a strategic plan. It shall respond to system barriers which the Practice Level Workgroup cannot resolve, making recommendations to the Executive ~~level~~Council as needed.
- (f) ~~(d)~~The Advisory Committee ~~consists~~must consist of representatives of ~~the Contractor, its providers, Providers, local public~~ child serving agencies ~~and other agencies including, young adults or Young Adult Peer Support, families and Family Partners, and advocacy organizations and reflective of local culture~~(Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) and must include meaningful participation from youth and family members.
- (g) ~~(e)~~The Executive Council shall develop and approve ~~related~~ policies, ~~and~~ shared decision-making regarding funding and resource development, review ~~of~~ project outcomes, and ~~identification~~of identify unmet needs in the ~~community~~community to support the expansion of the service array.
- (h) ~~(f)~~The Executive Council ~~consists~~must consist of representatives of the Contractor, ~~its providers, Providers, local public~~ child serving agencies ~~and other agencies including, young adults or Young Adult Peer Support, families and~~

~~Family Partners, and advocacy organizations and reflective of local culture~~(Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) and must include meaningful participation from youth and family members.

(3) ~~(4)~~ Contractor shall develop and provide to OHA the following items prior to December 31, 2020:

~~(a) — Charters and new Member handbooks for the Practice Level Work group, the Advisory Council and the Executive Council;~~

(a) ~~(b) An initial and ongoing~~A System of Care ~~Brief due annually to OHA affirming Contractor's commitment to upholding SOC principles~~Policy that ~~includes~~addresses the following components:

i. ~~A summary of local issues addressed through~~How Contractor meaningfully supports the leadership and involvement of Youth and families at all levels of the SOC governance structure.

ii. How Contractor supports and invests in a SOC that is both Culturally and Linguistically Appropriate to the needs of the communities in Contractor's Service Area.

iii. How Contractor supports the inclusion and collaboration of Community partners and system partners to ensure Youth and families have access to necessary supports and services?

(4) Contractor shall for each Contract Year prepare and submit quarterly reports to the System of Care Statewide Steering Committee (Statewide.SOC@dhsosha.state.or.us) on March 31, June 30, September 30 and December 31 beginning in CY 2020. Each report must include the following information:

(a) Barriers that were submitted by the community to the appropriate committee within the SOC governance structure;~~and~~

(b) Resolved and unresolved outcomes and barriers that were sent to the Statewide SOC Steering Committee;

(c) Sources of funding within the SOC governance structure and what type of funding was used;

(d) List of system partners involved; and

(e) ~~ii. The data~~ Data-informed priorities for the following ~~contract year~~Contract Year.

~~(e) — A quarterly report that tracks the barriers to implementing a SOC including resolved and unresolved barriers.~~

~~(d) — Contractor shall submit the documents described in this subsection to the State Steering Committee at statewideSOC@state.or.us.~~

~~e. — Child and Youth Screening~~

p. ~~(1)~~ The Child and Adolescent Needs and Strengths Comprehensive Screening (~~CANS~~ Oregon) is a multi-purpose tool developed to support decision making, including level of care and service

planning, to facilitate ~~quality improvement~~Quality Improvement initiatives, and to allow for the ~~monitoring~~Monitoring of outcomes of services and supports. ~~Only staff~~

(1) Contractor shall ensure only Providers who have been credentialed by the Praed Foundation for administering the CANS Oregon (as found at <https://tcomtraining.com>) shall administer CANS Oregon to Members.

(a) ~~(2)~~ Contractor shall ensure a CANS Oregon is administered to a Member ~~who is a child age seventeen (17) or youth younger~~ and the data is entered into OHA approved data system according to the following eligibility and timeline criteria:

- i.** ~~(a)~~ Within sixty (60) days of notification that a Member is entering foster care or from date of ~~referral~~Referral from DHS caseworker;
- ii.** ~~(b)~~ Annually for a Member who was rated a “Level of Care” of 1 or higher on the initial CANS and remains in foster care;
- iii.** ~~(c)~~ Within sixty (60) days of notification of the approval of a request for a CANS Oregon and upon DHS caseworker ~~referral~~Referral;
- iv.** ~~(d)~~ For Members being served through the high ~~fidelity~~Fidelity Wraparound care planning process according to timelines specified in ~~section (5) para. m. of sec. 40~~ of this ~~Contract~~Ex. M; or
- v.** ~~(e)~~ Members receiving ~~psychiatric day treatment~~Psychiatric Day Treatment Services.

~~f. — Provider Training for Wraparound Services~~

- ~~(1) — Contractor shall ensure providers (including Day Treatment, PRTS, SAIP and SCIP providers) have an understanding of Wraparound values and principles and the provider’s role within the child and family team. Contractor shall ensure providers collaborate and participate in the Wraparound process.~~
- ~~(2) — Contractor shall ensure that the Team Observation Measure tool (TOM) 2.0 is implemented by a trained rater as implemented by the Wraparound Coach or Wraparound Supervisor to Wraparound Care Coordinators a minimum of six times within their first year of employment and a minimum of two times thereafter. Outcomes from the tool shall be submitted to OHA twice a year. Submission dates shall align with due dates for the Child and Adolescent Needs Assessments.~~

20. 5. Reporting Reporting Requirements:

- a.** Contractor shall submit an annual Behavioral Health report to OHA on XXXX of each Contact Year on the Behavioral Health metrics set forth and described by OHA and published on the OHA website.
- b.** Metrics to be included in the Behavioral Health report will be determined by OHA and will assess:
 - (1)** ~~a. Integration Roadmap~~ Behavioral Health Integration;
 - (2)** Access to Behavioral Health Services;
 - (3)** Services for Members with SPMI;

- (4) Services for Children and Youth Members; and
- (5) Provider and staff training in ~~recovery principles, motivational interviewing, integration, and Foundations of Trauma.~~
- c. OHA will use the annual Behavioral Health report to assess Contractor's compliance with respect to its obligations to provide Behavioral Health services in accordance with the terms and conditions of this Contract, including but without limitation, timely access to care and network adequacy.
- d. OHA may use in its assessment, in addition to Contractor's annual Behavioral Health report, the following information, including but without limitation:
- (1) Behavioral Health needs of Members in Contractor's Service Area based on prevalence rates as determined by OHA.
- (2) EQRO reports; and
- (3) complaints, Grievances and Appeals.
- e. Unless another due date or submission process is expressly provided elsewhere in this Ex. M, Behavioral Health reports and any documentation required to be made under this Ex. M shall be submitted by Contractor to OHA via Administrative Notice for review and approval within five (5) Business Days after request from OHA. Contractor shall use the Behavioral Health reports template which is posted on the CCO Contract Forms Website. In the event that OHA does not approve Contractor's Behavioral Health report, Contractor must follow the process set forth in Ex. D, Sec. 5 to this Contract.
- f. Contractor shall report Behavioral Health cost and utilization data in accordance with Exhibit L Financial Report Template.
- ~~g. (1) Contractor shall report annually to OHA on the performance expectations in this section. Reports shall be submitted for review and approval to OHA. Contractor shall ensure that its subcontractors~~Subcontractors ~~and Participating Providers supply all required information to support the monitoringreporting process.~~
- ~~(2) Contractor shall report on timeliness of access to Behavioral Health services and the methodology used to make this calculation.~~
- ~~(3) Contractor shall report on the percentage of Members receiving Behavioral Health services and the methodology used to make this calculation~~
- ~~(4) Contractor shall report how Contractor ensures comprehensive screenings of Behavioral Health and physical health, using evidence-based screening tools, are occurring in physical, oral and Behavioral Health care settings and the methodology used to make described in this calculationsection.~~
- ~~(5) Contractor shall report on the percent of prior authorizations that are required out of the total number of behavioral health covered services and the percent of prior authorized services that are approved within three (3) days.~~
- ~~(6) Contractor shall report performance measures and implement evidence-based outcome measures, as developed by the OHA Metrics and Scoring Committee.~~
- h. (7) Contractor shall ensure all Behavioral Health providersProviders ~~enroll their~~Contractor's Members in the Measures and Outcomes Tracking System (MOTS), or a similar program as

specified by OHA. The details for MOTS reporting are located at the following website:
<http://www.oregon.gov/oha/amh/mots/Pages/index.aspx>.

- ~~(8) 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.~~
- ~~(9) Contractor shall report on cost and utilization of Behavioral Health services quarterly and annually in the Exhibit L.~~
- ~~(10) Contractor shall report on wait time to appointment for access to Behavioral Health services.~~
- ~~(11) Contractor shall collect data to accurately quantify the percentage of Members at OSH, that once determined Ready To Transition (RTT) by OSH, are:~~
- ~~(a) Discharged within 20 days;~~
 - ~~(b) Discharged into ACT services;~~
 - ~~(c) Discharged to Secure Residential Treatment Facilities; and~~
 - ~~(d) Admitted to ED, ACPF, OSH, or jail (or who die) within 30 days and 180 days of discharge.~~
- ~~(12) Contractor shall report on the percentage of Members receiving each of the following Behavioral Health services, categorized by MH and SUD, each quarter:~~
- ~~(a) ACT~~
 - ~~(b) Supported Employment~~
 - ~~(c) Peer Delivered Services~~
 - ~~(d) Non-Secure Residential~~
 - ~~(e) Residential~~
 - ~~(f) Acute Care~~
 - ~~(g) Emergency Department~~
 - ~~(h) State Hospital~~
 - ~~(i) Other~~
- ~~(13) Contractor shall report on the number of Members who are:~~
- ~~(a) Referred to ACT and the disposition of referral, in each of the following categories:~~
 - ~~i. Admitted to and receiving ACT;~~
 - ~~ii. Denials by ACT program;~~
 - ~~iii. Referral was reviewed for appropriateness;~~
 - ~~iv. The length of time for resolution;~~
 - ~~v. Referral resulted in an individual being enrolled in ACT;~~
 - ~~vi. Referral resulted in a denial of ACT services;~~

~~vii.—Referral resulted in the member being sent a Notice of Adverse Benefit Determination.~~

- ~~(14) Contractor shall report on the percentage of Members with SPMI admitted to ACPFs for MH diagnosis in each of the following categories:~~
- ~~(a) Discharged with documentation of linkages to appropriate behavioral and primary health care prior to discharge;~~
 - ~~(b) Discharged with documentation of warm handoffs;~~
 - ~~(c) Members that received a follow-up visit within 7 days;~~
 - ~~(d) Homeless members who are connected to a housing provider with an appropriate documented housing assessment;~~
 - ~~(e) Members who are readmitted within 30 and 180 days; and~~
 - ~~(f) Members in the categories above who are readmitted two or more times within six months.~~
- ~~(15) Contractor shall report on the number of Members with SPMI who are admitted to EDs for MH diagnosis including the following data points:~~
- ~~(a) The percent of Members who are admitted;~~
 - ~~(b) The range and average length of stay;~~
 - ~~(c) Whether the Member left the ED with appropriate connection to services and who have follow-up visit within 7 days; and~~
 - ~~(d) Whether the Member was readmitted to ED two or more times within six months.~~

~~b.—Reporting Children and Youth Members~~

- ~~(1) Contractor shall report on children receiving Wraparound services and supports quarterly.~~
- ~~(2) Contractor shall report on CANS data quarterly, using the OHA approved assessment and outcomes tool to the OHA approved reporting and analytics service system in order to track outcomes and review progress. Entries shall occur within 30 days of start of service, every 90 days after the initial entry and upon exit from service.~~
- ~~(3) Contractor shall report on children receiving high fidelity Wraparound Services using the OHA approved assessment and outcomes tool. Contractor shall submit the results of this assessment to the OHA approved reporting and analytics service system in order to track outcomes and review progress. Entries shall occur within 30 days of start of service, every 90 days after the initial entry and upon exit from service. These practices shall be in alignment with OAR 309 Wraparound Rule.~~

21. **6. Providers**

- a. Contractor shall ensure Contractor's ~~staff~~employees, subcontractors, and ~~providers~~Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (<https://traumainformedoregon.org/tic-intro-training-modules/>) and provide regular, periodic oversight and technical assistance on these topics; to ~~providers~~Providers.
- b. Contractor shall require ~~providers~~Providers, in developing ~~individual service and support plans~~Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (~~ACEs~~ACE), trauma and resiliency in a ~~culturally responsive~~Culturally and

- Linguistically Appropriate manner, using a ~~trauma-informed~~Trauma Informed framework—~~as indicated.~~
- c. Contractor shall ensure that ~~providers~~Providers who have a waiver under ~~The~~the Drug Addiction Treatment Act of 2000, ~~Title and 42 Section 3502-Waiver~~CFR Part 8. are permitted to treat and prescribe ~~Buprenorphine~~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.
 - d. Contractor shall ensure that employees or ~~providers~~Providers who evaluate Members for access to, and length of stay in, Substance Use Disorders programs and services use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R) for level of care placement decisions, and that they have the training and background necessary to evaluate medical necessity for Substance Use Disorder Services using the ASAM.
 - e. Contractor shall ~~report the number of staff trained in the previous 12 months on recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care.~~
 - f. ~~Contractor shall require~~recognize OHA's licensing standards for mental health and substance use disorder programs ~~be licensed or certified by OHA to enter the provider network if licensure is required by OHA.~~

~~Exhibit N—Social Determinants of Health and Health Equity~~

~~1. 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 representatives of the community and of each county government served by the Contractor, but consumer representatives must constitute a majority of the membership;
A consumer representative is defined as a person serving on a community advisory council who is a current OHP member or a parent/guardian/primary caregiver of a current OHP member; consumer representatives can be age 16 or older. If a consumer representative's membership in OHP ends, they can be counted as a consumer representative for six months after the end of membership but not after that time (though they may remain a CAC member).~~
 - ~~(2) Ensures diverse membership, with a specific emphasis on those representing populations who experience health disparities;~~
 - ~~(3) Has its membership selected by a committee comprised of an equal number of 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 414.627;~~
 - ~~(5) Posts a report of its meetings and discussions to the Contractor's CCO website and other websites as appropriate to keep 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, Contractor shall hold 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; as the minimum necessary requirements to enter the Provider Network.~~
 - ~~(d) Provide the opportunity for the public to provide written or oral comments; and~~
 - ~~(e) Posts to the Contractor's CCO website contact information for, at a minimum,
 - ~~i. The CAC chairperson; and~~
 - ~~ii. A member of the CAC or a designated staff member of the Contractor~~~~~~
 - ~~(7) Contractor is not required by OHA to subject meetings of the CAC to ORS 192.610 to 192.710, the Public Meetings Law.~~

- b. ~~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.~~
- e. ~~Contractor shall complete and submit to OHA a CAC member composition and alignment report that contains:~~
- ~~(1) Description of the demographic composition of CAC membership;~~
 - ~~(2) Description of data sources used to inform CAC alignment with Contractor's member demographics;~~
 - ~~(3) Description of barriers and efforts to increase alignment;~~
 - ~~(4) Description of how Contractor defines its member demographics and diversity;~~
 - ~~(5) Description of the intent and justification for CAC composition;~~
 - ~~(6) How Contractor's CAC representation is in alignment with CHP priorities and the percentage of OHP members on Contractor's CAC;~~
 - ~~(7) A description of the CAC's ongoing role in decision-making about HRS Community Benefit Initiatives, social determinants of health spending decisions, and other community-based initiatives; and~~
 - ~~(8) Contractor's organizational chart. **The organizational chart shall indicate:**~~
 - ~~(a) **How information flows between the CCO and CAC;**~~
 - ~~(b) The connection between the CAC, CCO Board of Directors and any other CCO committees;~~
 - ~~(c) The CAC representation on the CCO board of directors;~~
 - ~~(d) A narrative description of relationship between the CAC and CCO board of directors; and~~
 - ~~(e) All components described above, in relation to tribes and/or tribal advisory committee as applicable.~~
 - ~~(9) CAC reports shall be posted publicly on OHA's website, with demographics of CAC membership redacted.~~
 - ~~(10) The CAC report is due on June 30th of each year beginning June 30, 2021.~~

2. ~~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 and ORS 414.626. This includes, but is not limited to developing a CHA and CHP that:~~
- ~~(1) Is transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHP comply with ORS 414.627 and ORS 414.629;~~

- ~~(2) — Is a shared CHA and has shared CHP priorities and strategies with LPHAs, nonprofit hospitals, any other CCOs that share a portion of the Contractor’s service area, and any federally recognized tribe in the service area that is developing or already has a CHA and/or CHP;~~
 - ~~(3) — Includes in the CHP at least two State Health Improvement Plan (SHIP) priorities, based on local need and the statewide strategies being implemented;~~
 - ~~(4) — Includes SDOH HE partners and organizations, counties, THWs, and tribes in development of the CHA and CHP; and~~
 - ~~(5) — Involves school nurses, school mental health providers, and individuals representing child and adolescent health services in the development of the CHP.~~
- b. ~~To the extent practicable, Contractor shall include in the CHA and CHP a strategy and plan for:~~
- ~~(1) — Working with the Early Learning Council, Early Learning Hubs, 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/region; and~~
 - ~~(2) — Coordinating the effective and efficient delivery of health care to children and adolescents in the community.~~
- e. ~~A CHP must:~~
- ~~(1) — Be based on research, including research into adverse childhood experiences;~~
 - ~~(2) — Identify funding sources and additional funding necessary to address the health needs of children and adolescents in the community and to meet the goals of the plan;~~
 - ~~(3) — 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 and school nurse system, including the addition or improvement of electronic medical records and billing systems;~~
 - ~~(4) — Take into consideration whether integration of school-based health centers with the larger health system or system of community clinics would further advance the goals of the plan;~~
 - ~~(5) — Improve the integration of all services provided to meet the needs of children, adolescents, and families; and~~
 - ~~(6) — Focus on primary care, behavioral and oral health, and address promotion of health and prevention, and early intervention in the treatment of children and adolescents;~~
 - ~~(7) — Include, in the activities, services and responsibilities defined in the CHP, a plan and strategy for integrating physical, behavioral and oral health; and~~
 - ~~(8) — Include the findings of the CHA and the method for prioritizing health disparities for remedy.~~
- d. ~~Contractor, with its CAC, shall develop baseline data on health disparities. Contractor may seek guidance from the OHA Office of Equity and Inclusion in that development. Contractor shall include in the CHA the 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.~~
- e. ~~Contractor shall provide opportunities for IHCPs to contribute in the Contractor's development of the CHA and CHP, which may include the following actions: including tribes and IHCPs to contribute and gather health disparities data, identification of CHP priorities, and allowing IHCP feedback and review of the CHA and CHP.~~
- f. ~~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 shared community health assessment and any other applicable community health assessments completed within the Contractor's service area;~~
 - ~~(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 adequacy of existing school-based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community;~~
 - ~~(5) Analysis and development of public and private resources, capacities and metrics based on ongoing CHA activities and population health priorities;~~
 - ~~(6) Public Health Accreditation Board standards for CHPs;~~
 - ~~(7) Health policy;~~
 - ~~(8) System design issues and solutions;~~
 - ~~(9) Outcome and Quality Improvement plans and results;~~
 - ~~(10) Integration of service delivery approaches and outcomes; and~~
 - ~~(11) Workforce development approaches and outcomes.~~
- g. ~~Contractor shall provide a copy of the CHA and the CHP, and annual progress reports using the guidance and template provided by OHA at <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-CHP.aspx>, to the Contract Administration unit, on or before June 30th of each year. The CHA, CHP and annual progress report must be submitted as follows:~~
- ~~(1) The CHA and CHP must be updated at least every five years, but may be updated more frequently than every five years;~~
 - ~~(2) The updated CHA and CHP must be submitted along with the annual progress report;~~
 - ~~(3) If Contractor has an existing CHA or CHP that is not representative of the Contractor's current service area, Contractor must submit a new CHA and CHP in June 2021; and~~
 - ~~(4) The progress reports shall identify goals, benchmarks, and targets for priority areas, including data used to evaluate goals, benchmarks, and targets.~~

~~3.~~ **Social Determinants of Health and Health Equity**

- ~~a.~~ Contractor shall spend a portion of annual net income or reserves on services designed to address health disparities and the social determinants of health, according to requirements in Oregon Administrative Rule and ORS 414.625(1)(b)(C).
- ~~b.~~ Contractor shall submit to OHA, by March 15, 2020, an implementation plan using the template provided by OHA that includes the selected priorities for health disparities and SDOH HE required spending in the subsequent year. The selected priorities shall be aligned with the CHP and identified from analysis of any existing CHP priorities that meet the OAR SDOH HE definition and fall into one of four SDOH HE domains: **Economic Stability, Neighborhood and Built Environment, Education, and Social & Community Health**. Contractor must include the OHA designated statewide priority for SDOH HE spending, namely: housing related services and supports, including supported housing, as defined in this contract. Contractor shall comply with future statewide priorities as set by OHA. Contractor may select additional priorities aligned with CHP priorities according to community need. The plan shall identify **any infrastructure needs or gaps for addressing the selected priorities and ways to satisfy those needs or gaps.**
- ~~c.~~ Contractor shall submit to OHA, by April 30, 2021, a proposal for how Contractor intends to direct its SDOH HE spending for SDOH HE, for approval by OHA. OHA reserves the right to review and require changes to the proposal and to provide guidance on appropriate use of funds. The proposal shall include a description of the following:
- ~~(1)~~ A list of selected priorities, aligned with the Contractor's CHP, for SDOH HE spending, including justification of any changes from the Contractor's implementation plan;
 - ~~(2)~~ Identification of how projects or initiatives address a priority area of SDOH HE;
 - ~~(3)~~ How SDOH HE partner(s) were selected;
 - ~~(4)~~ **Any ownership, business, or financial relationship between SDOH HE partner(s) and Contractor, including a completed ownership disclosure form;**
 - ~~(5)~~ **An evaluation plan for each project or initiative, including expected outcomes, the number of OHP members and community members served, and how impact will be measured;**
 - ~~(6)~~ A budget proposal indicating the amount of funding that will be directed to each SDOH HE partner;
 - ~~(7)~~ Copies of all written agreements to SDOH HE partners for directed SDOH HE spending;
 - ~~(8)~~ A description of the CAC's role in selecting the proposed project; and
 - ~~(9)~~ A data sharing agreement that details applicable HIPAA and other state and federal privacy and security requirements for protected personal information sharing.
- ~~d.~~ Contractor shall enter into a formal written agreement with each SDOH HE partner(s) to direct a portion of required SDOH HE spending to SDOH HE partner(s). The agreement shall contain the following information and disclosures:
- ~~(1)~~ Contract term;
 - ~~(2)~~ Legal names for all entities;

- ~~(3) — Any relationship or financial interest that may exist between the SDOH HE partner and Contractor, including membership on the governance board or CAC;~~
- ~~(4) — The category of SDOH HE partner. If the partner does not qualify as one of the listed categories, CCOs must receive prior written approval from OHA;~~
- ~~(5) — How contractor will distribute funds to partners;~~
- ~~(6) — The scope of work to be performed, including the domain of SDOH HE addressed and the targeted population;~~
- ~~(7) — Whether Contractor will refer members to the SDOH HE partner;~~
- ~~(8) — The geographic area to be covered;~~
- ~~(9) — How Contractor will measure and evaluate outcomes; and~~
- ~~(10) — How Contractor will collect and report data related to outcomes.~~
- ~~e. — Contractor shall submit to OHA a copy of any agreement with SDOH HE partners no later than 30 days after the agreement is executed. Contractor shall submit to OHA copies of all agreements with SDOH HE partners for required 2021 spending with Contractor’s full proposal by April 30, 2021.~~
- ~~f. — Contractor shall provide narrative and financial reporting of expenditures to OHA in the manner prescribed by the agency.~~
- ~~g. — OHA intends to establish a two-year incentive arrangement—the SDOH HE Capacity Building Bonus Fund (“SDOH HE Bonus Fund”)—to offer monetary bonus payments above and beyond the capitation rate to Contractors that meet SDOH HE related performance milestones and metrics. Performance will be evaluated and payments awarded to qualifying Contractors beginning CY 2021. The SDOH HE Bonus Fund will be contingent on availability of funds under the Medicaid growth cap and any required CMS approval.~~
- ~~(1) — By November 2020, OHA will issue to Contractors:~~
- ~~(a) — The list of performance milestones, benchmarks, and specifications for CY2021~~
- ~~(b) — Full program documentation, including SDOH HE Bonus Fund structure, methodology and disbursement timeline for the subsequent year, published on the OHA website.~~
- ~~(c) — The estimated maximum payment each CCO could qualify to receive in CY 2021 if it meets all performance milestones under the program~~
- ~~(d) — The estimated percentage of CY 2021 capitation rates CCOs could qualify to receive in CY 2022 under the SDOH HE Bonus Fund (i.e. estimated percentage of CY 2022 payments)~~
- ~~(2) — Contractor shall align SDOH HE Bonus Fund expenditures with SDOH HE priorities for required spending, including the statewide priority of housing-related services and supports.~~
- ~~(3) — Contractor shall provide OHA with narrative and financial reporting of SDOH HE Bonus Fund expenditures, including any funds distributed to SDOH HE partners, in the manner and form required by OHA.~~

~~4.~~ **Health-Related Services**

- ~~a.~~ In addition to Covered State Plan Services, Contractor shall include Health-related services, in accordance with OAR 410-141-3150, 45 CFR §158.150 or 45 CFR §158.151 that are consistent with the goal of achieving Member wellness and the objectives of an individualized care plan, or the goal of improving population health and health care quality. Health-related services must be coordinated by the Contractor and may be in collaboration with the PCPCH or other PCP in the DSN. Health-related services must be administered in accordance with Contractor's policy.
- ~~b.~~ Services covered under this Contract may be substituted with or expanded to include Health-related services, in compliance with Contractor's policy, as agreed to by the Member and, **as appropriate, the family of the Member, as being an acceptable alternative.**
- ~~c.~~ Contractor shall establish written policies and procedures in alignment with the requirements in Oregon Administrative Rule for administering Health-related services. The policies and procedures shall **enable a Participating Provider to order and supervise the delivery of Health-related 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.
- ~~d.~~ Contractor shall develop, for implementation starting in 2021:
- ~~(1)~~ Internal measures of clinical value and efficiency that will inform delivery of services to members;
 - ~~(2)~~ A strategy to use health-related services to reduce avoidable health care services utilization and cost;
 - ~~(3)~~ A strategy for spending on health-related services to create efficiency and improved quality in service delivery; and
 - ~~(4)~~ A process analysis Contractor will use to evaluate investments in health-related services and initiatives to improve members Social Determinants of Health.

~~5.~~ **Health Plan**

~~a.~~ **Development of Plan**

- ~~(1)~~ Contractor shall develop and begin to implement a Health Equity Plan by the beginning of ~~CY2020.~~
- ~~(2)~~ Contractor shall annually update and submit its Health Equity Plan by March 15 of each contract year. Beginning in contract year 2021, Contractor shall submit an annual progress assessment. OHA will review Health Equity Plans submissions. Accountability measures will be developed and updated in consultation with the Oregon Health Policy Board's Health Equity Committee.
- ~~(3)~~ Contractor shall include in its annual progress assessment the following information related to its Health Equity Plan implementation:

- ~~(a) — Increased capacity and leadership for health equity and cultural responsiveness~~
- ~~(b) — How Contractor has used race, ethnicity, language and disability (REAL+D) and culturally and linguistically appropriate services (CLAS) in the organization and the provider network.~~

~~Guidance documents for the Health Equity Plan development will be provided by OHA.~~

- ~~(4) — The Health Equity Plan shall include a training program across Contractor's organization and its provider and subcontractor network and shall designate a single point of accountability within Contractor's organization to be accountable for its implementation.~~
- ~~(5) — The Health Equity Plan report includes three required sections:

 - ~~(a) — Narrative of the Health Equity Plan development process.~~
 - ~~(b) — Strategies, goals, objectives, activities, and metrics.—~~
 - ~~(c) — **Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan.**~~~~

~~b. — Narrative Health Equity Plan Development and Implementation—Requirements~~

~~The Narrative Section shall address each of the following components:~~

- ~~(1) — Description of the Contractor's organization and organizational commitment to Health Equity;~~
- ~~(2) — Narrative description of the general population served by Contractor, **Contractor's workforce demographics, and CAC demographic composition**, identifying the data source used to define the CAC demographic composition. If member demographic data is available, Contractor shall include it;~~
- ~~(3) — Description of Contractor's organizational oversight and accountability structure to support the implementation of the Health Equity Plan components. Description shall include the role of the single point of accountability for Health Equity Plan development and implementation;~~
- ~~(4) — Narrative description of how the Health Equity Plan was developed including stakeholder participation, CAC involvement, and how the Health Equity Plan will be updated. Contractor is expected to provide **evidence that the process for the development of the Health Equity Plan included clearly defined and realistic objectives that were community and stakeholder informed.** Evidence may include a description of how community and stakeholder engagement impacted the plan development process; how the Contractor informed potential participants of the proposed development, implementation and outcomes, and how the Contractor plans to provide regular updates to those community members and stakeholders involved in the development process;~~
- ~~(5) — Contractor's plan for community engagement and communication throughout the planning, implementation, and evaluation of the plan and its deliverables;—~~
- ~~(6) — An assessment of the Contractor's organizational capacity to advance health equity, **including stakeholder engagement, current capabilities and assets, and future goals for developing additional capacity;** and—~~

~~(7) Narrative description of the general expectations for the Health Equity Plan, expected organizational and community health impact of the strategies and initiatives included in the plan, and their influence in the social determinants of health and organization and community-wide efforts to reduce health inequities.~~

~~e. Strategies, Goals, Objectives, Activities, and Metrics—Requirements~~

~~The Strategies, Goals, Objectives, Activities and Metrics section shall include:~~

- ~~(1) Conflict and grievance resolution processes that are culturally responsive and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.~~
- ~~(2) Collection, analysis, and maintenance of accurate and reliable demographic data (i.e. REAL+D).~~
- ~~(3) Standards for and measurement of success of implementation of the Health Equity Plan over the five-year period. Contractor shall develop at least one strategy under each of the eight Health Equity Focus areas (CY 2020 years are listed below). OHA reserves the right to modify Health Equity Focus areas in future years.~~
- ~~(4) Provision of effective, equitable, understandable, and respectful quality care and services~~
- ~~(5) Organizational governance and leadership to promote health equity (i.e. incorporation of CLAS)~~
- ~~(6) Recruitment of culturally and linguistically competent leadership and workforce~~
- ~~(7) Training and education for culturally and linguistically responsive governance, leadership and workforce (i.e. Training activities such as Non-discrimination and civil rights, compliance with ACA 1557, utilization of Traditional Health Workers, community engagement, accessibility, among others)~~
- ~~(8) Language assistance accessibility, appropriateness, and quality of language services (i.e. use of qualified and certified healthcare interpreters; quality assessment of language service provision)~~
- ~~(9) Development and provision of materials (print, multimedia, etc.), plain language, alternate formats and the use of IT tools for patient/member engagement and education (i.e. literacy and plain language review, the offering of alternate formats, IT tools for patient engagement, including in languages other than English).~~
- ~~(10) Conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints~~
- ~~(11) Collection, analysis, and maintenance of accurate and reliable demographic data (REAL+D)~~

~~d. Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan—Requirements~~

~~(1) Contractor shall incorporate training activities into their existing organization-wide training plans that address Cultural Responsiveness and Implicit Bias in the workforce. Contractor shall require and provide training or ensure training is provided on implicit bias for all of Contractor's staff and provider network.~~

- ~~(2) Contractor shall use the criteria developed by the Cultural Competence Continuing Education Committee for the selection of training and education resources on cultural competency and responsiveness for Contractor's staff and provider network.~~
 - ~~(3) Contractor, when incorporating cultural responsiveness training activities into its training plans, shall adopt the definition of cultural competence in OAR 943-090-0010 for Cultural Competency Continuing Education for Health Care Professionals.~~
 - ~~(4) Contractor shall ensure that workforce and provider network training offerings include at a minimum the following fundamental areas or a combination of all:~~
 - ~~(a) Implicit Bias/Addressing structural barriers and systemic oppression~~
 - ~~(b) Language Access; Use of Health Care Interpreters~~
 - ~~(c) CLAS Standards~~
 - ~~(d) Adverse Childhood Experiences/Trauma Informed Care~~
 - ~~(e) Uses of data to advance health equity~~
 - ~~(f) Universal Access or accessibility in addition to ADA~~
 - ~~e. Contractor shall provide evidence that it has adopted the aforementioned criteria and core competencies.~~
 - ~~f. Contractor shall provide details of their training activities, including reporting of training subjects, content outlines, objectives, target audiences, delivery system, evaluations, training hours, training attendance, and trainer qualifications. Contractor shall supply this information when submitting its Health Equity Plan.~~
 - ~~g. Contractor shall set training goals and objectives that are measurable and that will enable Contractor and OHA to monitor and measure progress on the completion of trainings and the impact of training on the development of desired competencies.~~
 - ~~h. For CY2020 only:~~
 - ~~(1) The Health Equity Plan shall include the identification of a single point of accountability. The single point of accountability shall facilitate the transmission of information between OHA, the Health Equity Committee, and Contractor on health equity activities and the delivery of culturally responsive and linguistically appropriate services. The single point of accountability shall participate on Health Equity Committees and other committees and workgroups when required.~~
 - ~~(2) Contractor shall provide the following to OHA:~~
 - ~~(a) A description of the roles and responsibilities of the single point of accountability;~~
 - ~~(b) How the single point of accountability reports to CCO leadership; and~~
- ~~Evidence of the single point of accountability's budgetary decision-making and resource allocation authority.~~

~~6. Traditional Healthcare Workers~~

22. Mental Health Parity Reporting Requirements

- a. ~~Contractor shall implement the THW Integration and Utilization Plan developed as part of the application for RFA 4690. The THW Integration and Utilization Plan must describe how Contractor will:~~ Contractor shall annually draft a MH Parity Report which shall include all the documentation and reporting necessary, as determined by OHA, to demonstrate Contractor's compliance with 42 CFR Part 438, Subpart K and Sec. 22 of Ex E of this Contract regarding parity in mental health and SUD benefits. OHA shall review Contractor's MH Parity Report to confirm that any limitations (such as day limits, prior authorization requirements, or general provider availability) Contractor may have imposed on accessing mental health and SUD services are not substantially different from, or more limiting than, those for physical, medical, and surgical benefits.
- ~~(1) — Integrate THWs into the delivery of services;~~
 - ~~(2) — Communicate to members about the benefits and availability of THW services;~~
 - ~~(3) — Increase THW utilization;~~
 - ~~(4) — Implement THW Commission best practices;~~
 - ~~(5) — Measure baseline utilization and performance over time;~~
 - ~~(6) — Utilize the THW Liaison position to improve access to members and increase recruitment and retention of THWs in its operations.~~
- b. ~~Contractor shall work in collaboration with THW Commission to implement the Commission's best practices, and coordinate with the OHA Office of Equity and Inclusion for technical assistance on implementation as needed. Contractor shall provide the MH Parity Report to OHA's Contract Administrator by Administrative Notice using the format provided by OHA which is available on the CCO Contracts Forms Website. Contractor shall provide its MH Parity Report to OHA as follows:~~
- ~~c. — As part of the implementation of Contractor's THW Integration and Utilization Plan, Contractor shall clearly and consistently communicate to members about the benefits and availability of THW services.~~
 - ~~d. — Contractor shall collect data to measure the integration and utilization of THWs using the reporting template provided by OHA. Contractor shall collect and submit the information collected for Contractor's service area by April 1 of each contract year for data collected in the prior contract year.~~
Data to be collected and submitted includes:
 - ~~(1) — An assessment of member satisfaction with THW services;~~
 - ~~(2) — Ratio of THWs to the total number of members;~~
 - ~~(3) — Number of THWs employed by Worker Type (FTE/Contracted);~~
 - ~~(4) — Number of requests from members for THW services (by THW types);~~
 - ~~(5) — Number of engagements of THWs as part of the Member's Care Team (by THW types);~~
 - ~~(6) — Demographics of THWs and CCO membership: including Race, Ethnicity, Language, Disability.~~
 - ~~(7) — The number of clinic and community-based THWs~~
 - ~~e. — Contractor shall ensure that encounter claims are submitted for any THW interactions that are eligible to be submitted and processed as encounter claims.~~

~~Contractor shall collect data for each of the following THW types:~~

- ~~(1) — Community Health Workers~~
- ~~(2) — Doulas~~
- ~~(3) — Peer Support Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists~~
- ~~(4) — Peer Wellness Specialists including Adult Addictions, Adult Mental Health, Family and Youth Support Specialists~~
- ~~(5) — Patient Health Navigators~~

~~f. Contractor shall document the number of interactions between THWs and members in each setting:~~

- ~~(1) Clinic Setting Annually by no later than March 30 of the year following the reporting year;~~
- ~~(2) Non-Clinic Setting Within five (5) Business Days after there is a significant or material change in Contractor's processes or operations that affects parity;~~
- ~~(3) Community-Based Setting Within five (5) Business Days after Contractor adds or eliminates a Subcontractor delegated process or operations that affects parity; and~~

~~g. Contractor shall document and report to OHA on each type of payment model used by Contractor to reimburse THWs and the number of THWs paid under each payment model it utilizes.~~

~~h. Contractor shall designate an employee as a THW Liaison. The THW Liaison shall act as a hub for Members and THWs in the Contractor's service delivery system. Contractor shall utilize the THW Liaison position to improve access to Members and increase its recruitment and retention of THWs in its operations, and to implement the provisions of its THW Integration and Utilization Plan.~~

~~(4) Within five (5) Business Days after OHA request.~~

c. OHA will evaluate Contractor's MH Party Report to determine if Contractor's existing benefits and any non-quantitative treatment limitations are consistent with 42 CFR Part 438, Subpart K and Sec. 22 of Ex E of this Contract. In the event that OHA determines that Contractor's limitations on mental health and SUD services, as set forth in its MH Parity Report, do not demonstrate compliance with the requirements set forth in this Sec. 22, Ex. M, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

d. Contractor shall provide to OHA or its designee all documents, files, and information, and provide OHA or its designee access to all facilities, systems, and computers, related to the administration and provision mental health and SUD services as may be requested from time to time. Contractor shall provide all such requested information to OHA within fourteen (14) days of the date of such request, in a form and by the means directed by OHA in its request. In the event OHA or its designee requests access to Contractor's facilities, systems, or computer (or any or all of them), OHA and Contractor shall together identify a date and time for such access which such access must not exceed twenty (20) days from the date of OHA's request.

Exhibit C-Attachment 1
CCO Specific Rates

Attachment 1 -Exhibit D
Deliverables and Required Administrative Notices

Document comparison by Workshare 10.0 on Friday, July 5, 2019 7:22:17 PM

Input:	
Document 1 ID	file://C:\Users\etaus\OneDrive\Desktop\JUSTICE-#9274406-v4B-RFA_Appendix_B__2020_CCO_Contract_Template_.DOCX
Description	JUSTICE-#9274406-v4B-RFA_Appendix_B__2020_CCO_Contract_Template_
Document 2 ID	file://C:\Users\etaus\OneDrive\Documents\OREGON DOJ _ CCO Contract\FINAL DRAFT OF REASSEMBLED CONTRACT FOR JULY POSTING\CCO_2_0_Contract_Template_FINAL CLEAN_05 JAN 2019.docx
Description	CCO_2_0_Contract_Template_FINAL CLEAN_05 JAN 2019
Rendering set	Standard

Legend:	
Insertion	
Deletion	
Moved from	
Moved to	
Style change	
Format change	
Moved deletion	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	8295
Deletions	6009
Moved from	258
Moved to	258
Style change	0
Format changed	0

Total changes	14820
---------------	-------

~~Appendix A~~

EXHIBIT A - DEFINITIONS

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

1. Express definitions in Exhibit A.
2. Express definitions elsewhere in this Contract.
3. Definitions in the OARs cited in Exhibit A, and
4. Definitions in OARs not specifically cited in Exhibit A.

For purposes of this Contract, the terms below shall have the following meanings when capitalized. The meanings below shall apply when terms are capitalized. The meanings shall also apply when both capitalized and used:

- (i) with a possessive case (such as “s” or “s”),
- (ii) in noun form when defined as a verb or vice versa,
- (iii) used in a phrase or with a hyphen to create a compound adjective or noun,
- (iv) with a participle (such as “-ed” or “-ing”),
- (v) with a different tense than the defined term,
- (vi) 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 Contract that are not capitalized shall have the meanings listed below when the Parties mutually agree the context determines the term is intended to be used with the defined meaning.

Terms defined within the text of this RFA Contract (including its ~~Attachments and Appendices~~) and the resulting Contract, the terms below Reference Documents, Report templates) shall have the following meanings as provided when capitalized. If a term defined below is used without capitalization in this RFA, then the context determines whether the term is intended to be used with the defined meanings such terms are not listed below.

~~A. Terms defined in OAR 309-019-0105~~

~~Acute Care Psychiatric Hospital
Assertive Community Treatment (ACT)
Family Support
Local Mental Health Authority (LMHA)
Mobile Crisis Services
Peer
Peer-Delivered Services (PDS)
Peer Support Specialist
Peer Wellness Specialist~~

Psychiatrist
Psychologist
Qualified Mental Health Associate (QMHA)
Qualified Mental Health Professional (QMHP)

~~B. Terms defined in OAR 309-032-0311~~

~~Individual Service and Support Plan (ISSP)~~

~~C. Terms defined in OAR 410-120-0000~~

~~Acute~~
Adverse Benefit Determination
Adverse Event
Aging and People with Disabilities (APD)
Allied Agency
Ambulance
Ambulatory Surgical Center (ASC)
American Indian/Alaska Native (AI/AN)
American Indian/Alaska Native (AI/AN) Clinic
Ancillary Services
Area Agency on Aging (AAA)
Automated Voice Response (AVR)
Benefit Package
Behavioral Health
Case Management Services
Child Welfare (CW)
Children's Health Insurance Program (CHIP)
Citizen/Alien Waived Emergency Medical (CAWEM)
Claimant
Client
Clinical Record
Community Mental Health Program (CMHP)
Contested Case Hearing
Co-Payments
Cost Effective
Covered Services
Date of Receipt of a Claim
Date of Service
Declaration for Mental Health Treatment
Dental Services
Dentist
Department of Human Services (Department)
Diagnosis Related Group (DRG)
Diagnostic Services
Division
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
Emergency Department

~~Emergency Medical Condition~~
~~Emergency Medical Transportation~~
~~Emergency Services~~
~~False Claim~~
~~Family Planning Services~~
~~Federally Qualified Health Center (FQHC)~~
~~Fee-for-Service Provider~~
~~Fully Dual Eligible~~
~~Healthcare Common Procedure Coding System (HCPCS)~~
~~Health Evidence Review Commission~~
~~Health Insurance Portability and Accountability Act (HIPAA)~~
~~Hospice~~
~~Hospital~~
~~Indian Health Care Provider (IHCP)~~
~~Indian Health Service (IHS)~~
~~Inpatient Hospital Services~~
~~Laboratory~~
~~Laboratory Services~~
~~Liability Insurance~~
~~Managed Care Organization (MCO)~~
~~Medicaid~~
~~Medical Assistance Program~~
~~Medical Services~~
~~Medically Appropriate~~
~~Medicare~~
~~Medicare Advantage~~
~~National Correct Coding Initiative (NCCI)~~
~~Non-Covered Services~~
~~Non-Emergent Medical Transportation Services (NEMT)~~
~~Nurse Practitioner~~
~~Nursing Facility~~
~~Oregon Health Authority (Authority)~~
~~Oregon Youth Authority (OYA)~~
~~Overpayment~~
~~Pharmaceutical Services~~
~~Physician~~
~~Physician Assistant~~
~~Practitioner~~
~~Prepaid Health Plan (PHP)~~
~~Primary Care Provider (PCP)~~
~~Prior Authorization (PA)~~
~~Prioritized List of Health Services~~
~~Provider~~
~~Provider Organization~~
~~Qualified Medicare Beneficiary (QMB)~~
~~Quality Improvement~~
~~Recipient~~
~~Recoupment~~
~~Referral~~

~~Remittance Advice (RA)~~
~~Request for Hearing~~
~~Rural~~
~~Sanction~~
~~School Based Health Service~~
~~State Facility~~
~~Subrogation~~
~~Supplemental Security Income (SSI)~~
~~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 Hospital~~
~~Urban~~
~~Urgent Care Services~~
~~Usual Charge (UC)~~
~~Utilization Review (UR)~~

~~**D.— Terms Defined in OAR 410-141-3000**~~

~~Applicant~~
~~Application~~
~~Benefit Period~~
~~Business Day~~
~~CCO Payment~~
~~Cold-Call Marketing~~
~~Community Advisory Council (CAC)~~
~~Community Standard~~
~~Coordinated Care Organization (CCO)~~
~~Coordinated Care Services~~
~~Corrective Action or Corrective Action Plan~~
~~Dental Care Organization (DCO)~~
~~Department of Consumer and Business Services (DCBS)~~
~~Disenrollment~~

~~Enrollment~~
~~Exceptional Needs Care Coordination (ENCC)~~
~~Global Budget~~
~~Grievance System~~

~~Health-Related Services (HRS)~~
~~Holistic Care~~
~~Licensed Health Entity~~
~~Marketing~~
~~Mental Health Organization (MHO)~~
~~Non-Participating Provider~~
~~Participating Provider~~
~~Potential Member~~
~~Request for Applications (RFA)~~
~~Service Area~~
~~Treatment Plan~~

~~E. Terms defined in OAR 410-141-3270~~

~~Marketing Materials
Outreach
Outreach Materials~~

~~F. Terms Defined in ORS 414.018~~

~~Community
Region~~

~~G. Terms Defined in ORS 414.025~~

~~Alternative Payment Methodology
Community Health Worker
Personal Health Navigator
Quality Measure~~

~~H. Terms Defined by this RFA~~

~~1. “340B Drug” means a drug purchased at the prices authorized under Section 340B of the Public Health Service Act.~~

~~2. “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.~~

~~3. “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” means a type of health plan premium payment adopted by HHS under HIPAA.~~

~~“835 Payment/Remittance Advice Transaction” means a HIPAA adopted standard for explanation from a health plan to a provider about a claim payment that includes adjudication decisions about multiple claims.~~

~~4. “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” and “Administrative Performance Withhold” (or AP Withhold or APW) each 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.~~

~~5. “Abuse” means improper behaviors or billing practices including, but not limited to: has the meaning provided for in 42 CFR §455.2.~~

- ~~• 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.](#)

~~6.~~ **“Actuarial Report”** is defined in the Sample Contract, Exhibit C, Section 7.

[“Acute” has the meaning as provided in OAR 410-120-0000.](#)

~~7.~~ **“Acute Inpatient Hospital Psychiatric Care”** means Acute care provided in an Acute Care Psychiatric Hospital.

[“Acute Care Psychiatric Hospital” and “ACPH” each have the meaning as provided in OAR 309-019-0105.](#)

[“Adjudication” has the meaning provided in OAR 410-141-3000. For purposes of Encounter Data, “Adjudication” means the date on which Contractor has both \(a\) processed and \(b\) either paid or denied a Member’s claim for services.](#)

[“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 26, 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.](#)

~~8.~~ **“Administrative Performance Penalty”** ~~(or and “AP Penalty” or “APP)”~~ [each](#) 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 Abuse” means the abuse of an adult with a mental illness or a developmental disability as such terms abuse and adult are defined under ORS 430.735.](#)

~~9.~~ **“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 OAR 410-141-3230.](#)

~~10. “Affiliate” of, or person “Affiliated” with, a specified person~~ 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” means the report required to be submitted to OHA by Contractors that are affiliated with or contracted with an entity that provides services as a Medicare Advantage plan for the purpose of identifying the affiliated or contracted Medicare Advantage Plan(s).

“Agent” has the meaning provided in 42 CFR §455.101

“Aging and People with Disabilities” and “APD” each have 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.

“Ambulatory Surgical Center” and “ASC” each have the meaning as provided in OAR 410-120-0000.

“American Indian/Alaska Native” and “AI/AN” each have the meaning as provided in OAR 410-120-0000.

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

“Annual CHP Progress Report” means the annual Community Health Improvement Plan progress report required to be provided to OHA in accordance with Sec. 7, Ex. K to this Contract.

“Annual FWA Assessment Report” means that annual Fraud, Waste, and Abuse report required to be provided to OHA in accordance with Ex. B, Part 9 to this Contract.

“Annual FWA Audit Report” means that annual Fraud, Waste, and Abuse audit report required to be provided to OHA in accordance with Ex. B, Part 9 to this Contract.

“Annual FWA Prevention Plan” means that annual Fraud, Waste, and Abuse prevention plan required to be provided to OHA in accordance with Ex. B, Part 9 to this Contract.

“Annual FWA Referrals and Investigations Report” means that annual Fraud, Waste, and Abuse referrals and investigations required to be provided to OHA in accordance with Ex. B, Part 9 to this Contract.

“Annual Subcontractor Performance Report” means the written document created pursuant to Sec. 12, Para. a, Sub. Para. (11)-(12), Ex. B, Part 4 which contains an evaluation of a Contractor’s Subcontractor.

~~11. “Appeal” means a request for review of a~~ has the meaning as provided in OAR 410-141-3230.

“Notice of Appeal Resolution” is the notice of action/provided to Members relating to the resolution of an Appeal related to an Adverse Benefit Determination or other action taken by Contractor that is subject to the Grievance and Appeal System.

“Applicable Law(s)” means all State and federal statutes, rules, regulations, and case law applicable to a particular issue that is referenced or to this entire Contract, or both as may be applicable.

“Applicant” has the meaning as provided in OAR 410-141-3010.

“Application” has the meaning as provided in OAR 410-141-3010.

“Area Agency on Aging” and “AAA” each have the meaning as provided in OAR 410-120-0000.

“Assertive Community Treatment” and “ACT” each have the meaning as provided in OAR 309-019-0105. The Acronym “ACT” has the same definition.

12. **“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.

~~13. **“Assignment”** means the process by which a Client is deemed eligible to be assigned to Contractor, either in a manual or automated process.~~

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

“Automated Voice Response” and “AVR” each have the meaning as provided in OAR 410-120-0000.

14. **“Automatic Re-enrollment”** means a re-enrollment of a Member with the Contractor when the Client was ~~disenrolled~~ Disenrolled solely because ~~he or she loses~~ the Member lost Medicaid eligibility for a period of 2 months or less.

15. **“Baseline”** for each Incentive Measure means Contractor’s Baseline measurement for the Incentive Measure for the Baseline Year.

16. **“Baseline Year”** means the calendar year for which the Incentive Measures for a Measurement Year are compared.

~~17. **“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.~~

~~18. **“Behavioral Health Only (BHO) Member”** means an individual enrolled for BHO Covered Services only. An 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).~~

19. ~~“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 an BHO Member whenever those Behavioral Health services are Medically Appropriate for the BHO Member (i.e. CCO-E/G).~~

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

“Behavior Rehabilitation Services Program” has the meaning provided in OAR 410-170-0020(6).

20. ~~“Benchmark” for each Incentive Measure means the statewide benchmark published at <http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx>~~ <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.

21. ~~“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.~~

“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 Program” means the program administered by OHA for providing assistance to individuals needing treatment for breast or cervical cancer as such program is described in OAR 410-120-0400 and which makes use of Medicaid funds as authorized under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

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

22. ~~“CCO Administrative Rules” means OHA’s rules governing CCOs at OAR 410-141-3000 to~~ Capitation Payment” has the meaning as provided in OAR 410-141-3000.

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

“CCO Contract Forms Website” means the OHA website located at: <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>

“CCO Payment” has the meaning as provided in OAR 410-141-~~4120~~.3000

23. ~~“CCO Payment Rates” means the rates for CCO Payments to Contractor as set forth in Sample Contract, Exhibit C,~~
Attachment 1 of the Contract.

24. ~~“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.

~~25.~~ **“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.

~~26.~~ **“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~~ensures 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.

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

~~27.~~ **“Charge”** means the flow of funds from the Contractor to the OHA.

“Centers for Medicare and Medicaid” and **“CMS”** each means the federal agency within the Department of Health and Human services that administers Medicare and works in partnership with all fifty states to administer Medicaid

“Child Abuse” is Abuse of a Child as the terms Abuse and Child are defined under ORS 419B.005

~~28.~~ **“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.

~~29.~~ **“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.

“Child Welfare” and **“CW”** each have the meaning as provided in OAR 410-120-0000. The acronym **“CW”** has the same definition.

“Children's Health Insurance Program” and **“CHIP”** each have the meaning as provided in OAR 410-120-0000.

[“Citizen/Alien-Waived Emergency Medical” and “CAWEM” each have the meaning as provided in OAR 410-120-0000.](#)

30. **“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.](#)

31. **“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 410-141-3000.](#)

[“Clinical Record” has the meaning as provided in OAR 410-120-0000.](#)

32. **“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.

[“Cold Call Marketing” has the meaning as provided in OAR 410-141-3000.](#)

[“Community” has the meaning as provided in ORS 414.018\(5\)\(a\).](#)

[“Community Advisory Council” and “CAC” each have the meaning as provided in OAR 410-141-3000.](#)

[“Community Health Assessment” and “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” and “Community Improvement Plan” and “CHP” 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” has the meaning as provided in OAR 410-120-0000.](#)

[“Community Standard” has the meaning as provided in OAR 410-141-3000.](#)

“Consumer Representative” means a person who is 16 years old or older, serves on a Community Advisory Council, and is either (i) a current Member, or (ii) a parent, guardian, or primary caregiver of a current Member. If the Consumer Representative ceases to be a Member (or the person for whom the parent, guardian, or primary caregiver serves as a proxy ceases to be a Member), such Consumer Representative may continue to serve in the capacity of a Consumer Representative for a period of six months after such person ceases to be a Member. After the six month period has expired, the former Member or the former Member’s proxy may continue to sit on the Consumer Advisory Council but not in the capacity of a Consumer Representative.

“Contested Case Hearing” has the meaning as provided in OAR 410-141-3230.

“Continuity of Care” has the meaning as provided in OAR 410-141-3080.

~~33.~~ **“Contract”** means ~~at this~~ Contract inclusive of all Exhibits, Attachments, Appendices, as set forth in Section V of the General Terms awarded to Contractor as a result of ~~this~~ RFA OHA-4690-19-0 tlh.

“Contract Administrator” means either Contractor’s or OHA’s staff member who is at point for administering and performing other duties related to the administration of this Contract, including, without limitation, serving as the default point person for receiving and distributing as necessary deliverables, Administrative Notices, Legal Notices, and other communications.

“Contract Effective Date” means the date the Contract becomes effective, which is October 1, 2019 and as identified in Section 1 of the General Terms of this Contract

“Contract Expiration Date” means, in accordance with ORS 414.652(1)(a) December 31, 2024

“Contract Health Services” and “CHS” each means a federal funding source designed to provide specialty care services to eligible Native Americans when services are unavailable at a tribal clinic.

“Contract Year” means the twelve-month period during the Term that commences on January 1 and runs up to and through the end of the day on December 31 of each calendar year.

~~34.~~ **“Contractor”** means an Applicant selected through ~~this~~ RFA ~~to enter~~ OHA-4690-19-0 tlh and is the ~~party that entered~~ into ~~at this~~ Contract with OHA ~~to perform the Work~~.

~~35.~~ **“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” and “CCO” each have the meaning as provided in OAR 410-141-3000.

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

“Coordination of Benefits Agreement” and “COBA” each means the contract required to be entered into, pursuant to 42 CFR §438.3(t), by and between Contractor and CMS that establishes the order in which Contractor and CMS will pay for the claims of Full Benefit Dual Eligible Members. By entering

into a Coordination of Benefits Agreement and obtaining a COBA number, Contractor will be able to participate in the automated crossover claims process.

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

“Corrective Action” and “Corrective Action Plan” each have the meaning as provided in OAR 410-141-3000.

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

“Coverage Effective Date” means January 1, 2020 and is the date on which New and Existing Members commence receiving services from or on behalf of Contractor under this Contract.

“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.

“CHIPRA” means the Children’s Health Insurance Program Reauthorization Act of 2009.

~~36.~~ **“Cultural Competence”** ~~means~~has the ~~same as~~ ~~“Cultural Awareness”~~meaning 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.

~~37.— “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.~~

~~38.— “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.~~

~~39.— “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.~~

“Culturally and Linguistically Appropriate Services” means the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The acronym “CLAS” has the same meaning. For more information relating to CLAS standards, see the following URLs:

<https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf> and <https://www.thinkculturalhealth.hhs.gov/>

“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.

“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.

“Dental Care Organization” has the meaning as provided in OAR 410-141-3000. The Acronym **“DCO”** has the same 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” and **“DCBS”** have the meaning as provided in OAR 410-141-3000.

“Department of Human Services” and **“DHS”** have the meaning as provided in OAR 410-120-0000.

“Diagnosis Related Group” and **“DRG”** have the meaning as provided in OAR 410-120-0000.

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

“Disclosing Entity” has the meaning provided in 42 CFR 455.101

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

~~40.~~ **“Distribution Year”** means the calendar year following the Measurement Year.

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

“DUR Program” means the drug utilization review program that complies with 42 CFR §438.2(s) and 42 CFR Part 456, Subpart K.

“Dual Special Needs Plan” and **“DSN Plan”** means a specific type of Medicare Advantage Plan for those individuals who have special needs as defined in 42 CFR §422.2 and meet the eligibility requirements set forth in 42 CFR §422.52.

“Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies” and **“DMEPOS”** have the meaning as provided in OAR 410-120-0000.

~~41.~~ **“Dyadic Treatment”** means a developmentally appropriate, evidence supported therapeutic intervention which is designed to actively engage one caregiver ~~and~~ with one child together during the intervention to reduce symptomology in one or both participants, and to improve the caregiver-child relationship.

~~42.~~ **“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.

~~43.~~ ~~“Effective Date” means the date the Contract becomes effective, as described in Section I.A of the Contract.~~

[“Elder Abuse” is abuse of an elderly person with or without disabilities as the terms abuse and elderly person are defined ORS 124.050.](#)

44. **“Electronic Health Record” and “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.

45. **“Emergency Dental Condition”** has the meaning ~~defined~~ provided in OAR 410-120-0000 ~~(69)~~.

[“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.](#)

46. **“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.](#)

47. **“Encounter Data”** means ~~encounter claims data that are~~ certain information required to be submitted to OHA under OAR 410-141-3430 and related to services that were provided to Members regardless of whether the services provided: (i) were Covered Services, non-covered services, or other health-related services, (ii) were not paid for, (iii) paid for on a fee-for-service or capitated basis, (iii) were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor, and (iv) were performed pursuant to Subcontractor agreement, special arrangement with a facility or program; or other arrangement.

48. **“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.

49. ~~“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.~~

[“Enrollment” has the meaning as provided in OAR 410-141-3000.](#)

[“Entity” has the meaning provided in OAR 141-410-3000.](#)

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

[“Existing Member” means a Member who is Enrolled with Contractor as of December 1, 2019 and who is scheduled to continue to be Enrolled with Contractor by OHA as of January 1, 2020.](#)

~~51.~~ **“Expiration Date”** means December 31st of each calendar year during the term of the Contract.

~~52.~~ **“External Quality Review Organization”** ~~or~~ [and “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. [The Acronym “EQRO” has the same definition.](#)

~~53.~~ **“External Quality Review”** ~~or~~ [and “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.

~~54.~~ **“Family Partner”** [The Acronym “EQR”](#) has the same [definition.](#)

[“False Claim” has the meaning as Family Support Specialist as defined provided in OAR](#)

~~410-180-0305(13)(d), 120-0000.~~

~~55.~~ **“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.](#)

[“Federally Qualified Health Center” and “FOHC\)” each have the meaning as provided in OAR 410-120-0000.](#)

[“Fee-for-Service” and “FFS” each 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.](#)

~~56.~~ **“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 SMED Report” means that final Subject Month Encounter Data Report described in Ex. B, Part 8, Section 13 of the Contract](#)

~~57.~~ **“Final Submission Month”** means six months after the last day of the Subject Month.

“Fiscal Agent”— has the meaning provided in 42 CFR 455.101

“Four Quadrant Clinical Integration Model”

~~58.~~ **“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. The term **“Full Benefit Dual Eligible”** and the acronym **“FBDE”** have the same meaning as Fully Dual Eligible.

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

~~59.~~ **“Governance Structure”** ~~or~~ **and “Governing Board”** each means the Board of Directors or Board of Trustees of a corporation, or the comparable governing body for any other form of Legal Entity.

~~60.~~—

~~“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—~~

~~61.~~— **“Habilitation Services”** means the services set forth in OAR 410-172-0700. has the meaning as provided in OAR 410-141-3230.

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

“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>

“HIT Commons” means the shared public/private governance model designed to accelerate and advance Health Information Technology adoption and use across the State. It is co-sponsored by Oregon Health Leadership Council and Oregon Health Authority and responsible for overseeing two major initiatives: Oregon Emergency Department Information Exchange/PreManage and Oregon Prescription Drug Monitoring Program (PDMP) Integration

“Home and Community Based Services” and **“HCBS”** means home and community based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. The acronym **“HCBS”** has the same meaning.

~~62.~~ **“Health Care-Acquired Condition”** has the meaning defined in 42 CFR 447.26(b).

~~63.~~ “Health Care Professional” has the meaning as provided in OAR 410-120-0000.

“Health Equity Plan” means the health equity plan required to be drafted by Contractor and provided to OHA in accordance with Ex. K

“Health Evidence Review Commission” and “HERC” have the meaning as provided in OAR 410-120-0000.

“Health Information Exchange” and “HIE” ~~means~~ mean the electronic movement of health information among disparate organizations and health information systems.

“Health Information System” and “HIS” mean information technology systems that meet the requirements set forth in 42 CFR §438.242 and Section 1903(r)(1)(F) of Patient Protection Affordable Care Act of 2010 as amended from time to time.

“Health Information Technology” and “HIT” means the technology that serves as the foundation for Health System Transformation and administration of the services provided by CCOs under their contracts with OHA and which (i) enables care coordination among Providers, (ii) contains costs through the sharing of medical information useful in diagnosis and treatment decision making, (iii) facilitates patient registries, (iv) enables unified quality reporting, and (v) empowers Members to participate in their overall wellness and health.

“Health Insurance Portability and Accountability Act” and “HIPAA” have the meaning as provided in OAR 410-120-0000.

“Health System Transformation” has the meaning provided in OAR 410-141-3000.

“Healthcare Common Procedure Coding System” and “HCPCS” each have the meaning as provided in OAR 410-120-0000.

“Healthcare Payment Learning and Action Network” and “LAN” each means the public private partnership whose mission is to accelerate the health care system’s transition to alternative payment models (APMs) by aligning the innovation, power, and reach of the private and public sectors. The LAN’s purpose is to facilitate the shift from the fee-for-service (FFS) payment model to a model that pays providers for quality care, improved health, and lower costs. The partnership was launched in 2015 by the HHS.

“Health-Related Services” and “HRS” each have the meaning as provided in OAR 410-141-3000 and as described in OAR 410-141-3150.

“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 the sums? amount of money? Revenue? included in the Hepatitis C DAA adjustment specified in the Contractor Rates as set forth in Attachment 1 to Exhibit C of the Contract 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 Exhibit C of the Contract 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.

~~64.~~ **“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 \(e.g. community health workers stationed in affordable housing communities\).](#)

~~65.~~ **“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](#) ~~by which Contractor’s performance~~ on each Incentive Measure is to improve during the Measurement Year by comparison with the Baseline.

~~66.~~ **“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.

~~67.~~ **“Initial Procurement Expense”** means ~~expenses for physical, behavioral, dental and NEMT services including prescription drugs except for Hepatitis C DAA Drugs.~~

~~68.~~ **“Initial Procurement Risk Corridor Period”** means ~~January 1, 2020 through June 30, 2020.~~

[“Indian” has the meaning as provided in OAR 410-141-3000.](#)

[“Indian Health Care Provider” and “IHCP” each have the meaning as provided in OAR 410-141-3000.](#)

[“Indian Health Service” and “IHS” each have the meaning as provided in OAR 410-120-0000.](#)

[“Individual Service and Support Plan” and “ISSP” each have the meaning as provided in OAR 309-032-0311](#)

~~69.~~ **“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.~~ **“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 Coordination” and “ICC” each have the meaning as provided in OAR 410-141-3000.](#)

~~70.~~ **“Intensive Care Coordinator” (ICC)** ~~has the meaning~~ means a person or entity providing “Intensive Care Coordination” services as defined in OAR 410-141-3170.

~~71.~~ **“Intensive Care Coordination Plan” (and “ICCP)”** each 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.

~~72.~~ **“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.

~~73.~~ **“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.

~~74.~~ **“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. The Acronym “ITS” has the same definition.

~~75.~~ **“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 of this Contract~~.

~~76.~~ **“Hepatitis C DAA Drugs”** ~~means the class of direct acting antiviral (DAA) drugs to treat Hepatitis C.~~

~~77.~~ **“Hepatitis C DAA Expense”** ~~means encounters with a paid amount recorded for Hepatitis C DAA drugs during the Hepatitis C Risk Corridor Period.~~

~~78.~~ **“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.~~

~~79.~~ **“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.~~

~~80.~~ **“Hepatitis C Risk Corridor Period”** ~~means January 1, 2020 through December 31, 2020.~~

~~81.~~ **“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).~~

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

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

~~82.~~ **“Learning Collaborative”** means a program in which CCOs, state agencies, and PCPCHs ~~can do the following, as well as other~~ that provide or perform the activities that serve Health System Transformation objectives ~~and, achieve,~~ the purposes of the Contract:

- ~~a.~~ Share, and share: (i) information about Quality Improvement;
- ~~b.~~ Share information (ii) and best practices about methods to change payment to pay for quality and performance;
- ~~c.~~ Share (iii) best practices and emerging practices that increase access to Culturally Responsive and linguistically appropriate care and reduce health disparities as defined in OAR 410-141-AAAA;
- ~~d.~~ Share (iv) best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care; ~~e.~~ Coordinate efforts to develop and test methods to align financial incentives to support PCPCHs;
- ~~f.~~ Share (v) 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;
- ~~g.~~ Share (vi) best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services;
- ~~h.~~ Share (vii) information and best practices on the use of Health-Related Services; and
- ~~i.~~ Share (viii) information and best practices on Member engagement, education and communication.

“Legal Holiday” means the days described in ORS 187.010 and 187.020.

“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 26, Paragraph a. of this Contract.

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

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

~~83.~~ **“Licensed Medical Practitioner—(LMP)”** means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (“LMHA”) or designee: ~~a.~~ 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 ~~b.~~ 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. The acronym “LMP” has the same definition.

“Lien Release Template” means that lien release template Contractor is required to create and submit to OHA under Exhibit B, Part 8 Section 17, Paragraph h of the Contract.

“Local Community Mental Health Program” and “CMHP” each means a program as described in ORS 430.630.

“Local Mental Health Authority” and “LMHA” each have the meaning as provided in OAR 309-019-0105.

~~84.~~ **“Long- Term Psychiatric Care”** ~~or~~ **and** **“LTPC”** **each** 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.

~~85.~~ **“MAT”** ~~means~~ **Medication Assisted Treatment**

~~86.~~ **“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.~~

~~87.~~ **“MMLR Rebate Report”** ~~means Contractor’s report of financial information required for calculating MMLR.~~

~~88.~~ **“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.~~

~~89.~~ **“MMLR Standard”** ~~means an MMLR exceeding 85% for the Contractor’s total Member population.~~

“Long Term Services and Supports” and **“LTSS”** each have the meaning provided in OAR 410-141-3000.

“Managed Care Organization” and **“MCO”** each have the meaning as provided in OAR 410-120-0000. The acronym **“MCO”** has the same definition.

“Managing Employee” has the meaning provided in 42 CFR §455.101

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

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

“Materials Manager” means the person who manages the team of OHA staff within OHA’s Business Operations Unit responsible for reviewing and approving CCO materials subject to review and approval under the Contract.

~~90.~~ **“Measurement Year”** means the preceding calendar year.

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

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

“Medical Loss Ratio” and **“MLR”** means the proportion of revenues spent on clinical services and quality health improvements compared to the proportion of revenue spent on overhead expenses such as marketing, salaries, administrative costs and the like.

“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.

“Medicare Advantage Plan” and “MA Plan” each means a Medicare Plan that meets the criteria set forth in 42 CFR Subchapter B, Part 422.

“Medication Assisted Treatment” and “MAT” each means the use of medications in combination with counseling and Behavioral Health therapies for treatment of SUD.

~~91.~~ **“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.

~~92.— “Member Months” means Contractor’s average number of Members during a quarter, multiplied by the number of months.~~

“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.

“Member Handbook” means the handbook that includes all of the information and documentation required under, 42 CFR §438.10 and the terms and conditions of this Contract, including, without limitation, Exhibit B, Part 3, and which is provided to Contractor’s Members in accordance therewith.

~~93.~~ **“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~~their parent or legal guardian.

~~94.— “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.~~

95. ~~“Membership Service Area” means:~~

- ~~a. 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~~
- ~~b. 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.~~

96. ~~“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 Organization” and “MHO” each have the meaning as provided in OAR 410-141-3000.

97. ~~“Mental Health Rehabilitative Services” means coordinated Assessment, therapy, consultation, medication management, skills training and interpretive services.~~

98. ~~“Metrics and Scoring Committee” means the subcommittee established in accordance with ORS 414.638(1).~~

“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.

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

“Monitor” means to (i) observe and check the progress or quality of something, (ii) undertake some acts over a period of time, (iii) to otherwise engage in activities, or (iv) any combination, or all, of the foregoing, which enables the party or persons undertaking such observations, acts, or activities to determine the quality, progress, or compliance (or any and all combination thereof) of the activities that are subject to observation, acts, or activities.

“MWESB” means Minority-owned, Women-owned, and Emerging Small Businesses as such terms are used in Oregon Executive Order 12-03.

99. ~~“NAIC” means National Association of Insurance Commissioners and has the meaning as provided in OAR 410-141-3000.~~

“NOTL” means Non-quantitative treatment limitation.

[“National Correct Coding Initiative”](#) and [“NCCI”](#) each have the meaning as provided in OAR 410-120-0000. The acronym [“NCCI”](#) has the same definition.

[“National Drug Code”](#) and [“NDC”](#) each means the unique three segment number assigned to each drug subject to commercial distribution and which is used and serves as a universal product identifier.

[“National Practitioner Data Bank”](#) means the web-based repository of report containing information on medical malpractice payment and certain adverse actions related to health care practitioners, providers, and suppliers which was established by Congress in 1986.

[“National Provider Identifiers”](#) and [“NPIs”](#) each means the is a unique 10-digit identification number issued to health care providers in the United States by the CMS.

[“Network Provider”](#) has the meaning provided for in 42 CFR §438.2

~~100.~~ [“Neuropsychiatric Treatment Service”](#) ~~or~~ and [“NTS”](#) each 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.

[“New Affiliated Entity”](#) means an Entity that is an Affiliate of Contractor that results from a consolidation, merger, sale, conveyance, or disposition by and between an Affiliate of Contractor and a third-party as described in Para. b, Sec. 20 of Ex. B-P.8 of this Contract.

[“New Entity”](#) is an Entity that is the result of a consolidation, merger, sale, conveyance, or disposition by and between Contractor and a third-party as described in Para. a, Sec. 20 of Ex. B-P.8 of this Contract.

[“New Member”](#) means a Potential Member who is not Enrolled with Contractor as of December 1, 2019 but who is scheduled to be Enrolled with Contractor by OHA as of January 1, 2020.

[“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 Provider”](#) has the meaning as provided in OAR 410-141-3000.

~~101.~~ [“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”](#) has the meaning as provided in OAR 410-141-3230. The acronym [“NOABD”](#) has the same definition.

[“Notice of Appeal Resolution”](#) means Contractor’s notification to a Member of the resolution of an Appeal as described in OAR 410-141-3247.

[“Notice of Encounter Data Delay”](#) means the notice Contractor is required to provide to its designated Encounter Data Liaison as set forth in Ex. B, Part 8, Sec. 9

[“Nurse Practitioner”](#) has the meaning as provided in OAR 410-120-0000.

[“Nursing Facility”](#) has the meaning as provided in OAR 410-120-0000.

~~102.~~ **“OEBB”** means the Oregon Educators Benefit Board within OHA.

~~103.~~ **“Office of Contracts and Procurement” (OC&P)** means the office that is responsible for the procurement and contracting process for OHA. [The acronym “OC&P” has the same definition.](#)

~~104.~~ **“OHP”** means Oregon Health Plan [and has the meaning as provided in OAR 410-141-3000.](#)

~~105.~~ **“OHPB”** means the Oregon Health Policy Board.

~~106.~~ **“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.

~~107.~~ **“Open Enrollment”** means a period where Members who reside in a Choice Area may make changes to their CCO Enrollment.

[“Oral Health”](#) has the meaning provided in OAR 410-141-3000.

[“Oral Health Provider”](#) means a Provider who provides Oral Health services.

[“Oregon Health Authority,” “Authority” or “OHA”](#) each have the meaning as provided in OAR 410-120-0000.

~~108.~~ **“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.

~~109.~~ **“Oregon Patient/Resident Care System”** ~~or~~ **and “OP/RCS”** [each](#) 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.

~~110.~~ **“OSH”** means Oregon State Hospital.

[“Oregon State Public Health Laboratory”](#) and [“OSPHL”](#) is the State laboratory that protects the public health by, among other efforts, supporting infectious disease prevention efforts and assures the quality of testing in clinical and environmental laboratories.

[“Oregon Youth Authority”](#) and [“OYA”](#) each have the meaning as provided in OAR 410-120-0000.

[“Other Disclosing Entity”](#) has the meaning provided in 42 CFR §455.101

“Other Primary Insurance” means any insurance that may or will provide coverage for Covered Services to a Member including, without limitation, auto-liability insurance, private health insurance, private disability insurance, or any other insurance that is not paid for with government funds as described in Ex. B, Part 8, Section 16 of the Contract.

“Other Provider-Preventable Condition” has the meaning defined in 42 CFR§ 447.26(b).

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

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

“Overpayment” has the meaning set forth in 42 CFR §438.2.

“Ownership Interest” has the meaning provided in 42 CFR §455.101

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

~~111.~~ **“Patient Protection and Affordable Care Act”** ~~or~~ and **“PPACA”** each 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).

~~112.~~ **“Patient-Centered Primary Care Home”** ~~or~~ and **“PCPCH”** each 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.

~~113.~~ **“Payment”** means the flow of funds from OHA to Contractor.

“PAHP” means Preambulatory Health Plans

~~114.~~ **“PEBB”** means the Public Employees Benefit Board ~~within OHA.~~

“PIHP” Prepaid Inpatient Health Plans

“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.

“Performance Data” means the data submitted by Contractor to OHA in connection with the Performance Measures deliverables required under 42 CFR §438.330(a) and (c) and as set out in further detail in Ex. B, Part 10 of the Contract.

“Performance Improvement Projects” means those activities required, pursuant to 42 CFR §438.330, to be undertaken by Contractor that must be designed to achieve significant improvement, sustained over

time, in health outcomes and Member satisfaction and meet the elements set forth in 42 CFR §438.330(d) and as set forth in further detail in Ex. B, Part 10 of the Contract.

“Performance Issues” means those issues or deficiencies identified by OHA indicating that (i) quality or access to services are not being provided as required under the Contract, (ii) cost containment goals are being compromised, (iii) circumstances exist that effect Member rights or health, or (iv) any combination of or all of the forgoing issues. One or more Performance Issue constitutes a breach of this Contract.

“Performance Measures” means those Measures identified by OHA and required to be reported to OHA by Contractor in accordance with 42 CFR §438.330(c) and as set forth in further detail in Ex. B, Part 10 of the Contract.

“Person” means any individual, partnership, corporation, association, public or private entity. For purposes of this definition, a public entity means State and local agencies and any other agency except federal agencies and except the State and federal courts. See 42 CFR §401.102

“Person with an Ownership or Interest” has the meaning provided in 42 CFR §455.101

~~115.~~ **“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 Lien” means a lien for Personal Injuries (as such term is defined under OAR 461-195-0301) that is subject to administration by OHA and DHS under OAR 461-195-0303. The acronym “PIL” has the same meaning.

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

“Pharmacy Benefit Manager” and “PBM” means the third party administrator of prescription drug programs for health insurance plans, including Medicaid.

“Pharmacy Encounter Data” means pharmacy related data that is required to be submitted to OHA pursuant to OAR 410-141-3430.

“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”

~~116.~~ **“Post Stabilization Services”** means Covered Services related to an ~~Emergency~~ ~~Medical~~ ~~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~~theMember's care and a Contractor Physician is not available for consultation.

~~117.~~—**“Previous**

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

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

“Predecessor CCO Contract” and **“Predecessor Contract”** each means a contract entered into by Contractor ~~s contract with~~ and OHA for ~~Coordinated Care Services that expired immediately before the Effective Date of the Contract.~~ the same or similar services as those provided under this Contract which was awarded to Contractor in response to RFA # 3402 and expired or is anticipated to expire on December 31, 2019.

“Preferred Drug List” means a list: (i) of prescription drugs that are identified by Contractor's pharmacy and therapeutics committee as the preferred drug for prescription within a therapeutic drug class, and (ii) that complies with OAR 410-141-3070. The acronym “PDL” has the same meaning.

“Prepaid Health Plan” and **“PHP”** each means has the meaning as provided in OAR 410-120-0000.

“Primary Care Provider” and **“PCP”** each have the meaning as provided in OAR 410-141-3000.

“Primary Prevention” means preventing the onset of a disease or other medical condition by intervening, prior to the onset of any ill effects, with the goal of reducing risks or threats to health utilizing measures such as vaccinations, exercise, and altering or otherwise ceasing to engage in, unhealthy or unsafe behaviors (e.g. poor diet, tobacco use).

“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.

~~118.~~—**“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.

“Proposed Final SMED Report” means that proposed Subject Month Encounter Data Report described in Ex. B, Part 8, Section 13 of the Contract

“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.

~~119.~~ **“Provider Panel” or “Provider Network”** means those Participating Providers Affiliated with the Contractor who are authorized to provide services to Members.

~~120.~~ **“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.

~~121.~~ **“Psychiatric Day Treatment Services”** ~~and “PDTS”~~ **each** means the comprehensive, interdisciplinary, non-residential, Community-based program consisting of psychiatric treatment, Family treatment and therapeutic activities integrated with an accredited education program.

~~122.~~ **“Psychiatric Residential Treatment Service”** ~~or~~ and **“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.

“Qualified Medicare Beneficiary” and **“OMB”** each have the meaning as provided in OAR 410-120-0000.

“Qualified Mental Health Associate” **“QMHA”** each have the meaning as provided in OAR 309-019-0105.

“Qualified Mental Health Professional” and **“QMHP”** each have the meaning as provided in OAR 309-019-0105.

“Quality Assurance and Performance Improvement” and **“QAPI”** each means the comprehensive quality assessment and performance improvement strategies and activities required to be identified and undertaken by Contractor as set forth in 42 CRF §438.330 and OAR 410-141-3200(8).

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

“Quality Measure” has the meaning as provided in ORS 414.025.

~~123.~~ **“Quality Pool”** means dollar amounts that OHA will pay CCOs as incentives for performance on Incentive Measures specified in the Exhibit C.

~~124.~~ **“Race, ethnicity, preferred spoken and written languages and disability status standards”**

~~or~~ and

“REAL-+D standards” ~~means~~ each mean standards under ORS 413.161.

~~125.~~ **“Readiness Review”** means a determination by OHA that an Applicant or CCO is qualified to hold a

CCO Contract.

126. “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.

“Recoup” or “Recoupment” means the withholding by OHA of all or a portion of one or more a future payments that may be owing to Contractor or a third-party to setoff amounts that are owing to OHA.

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

“Reference Document” means (i) those report templates, reference documents, or other documentation referred to in the Contract, (ii) required or otherwise recommended to be used or referenced in performing the obligations or meeting the conditions of the Contract, and (iii) posted on or accessed through one or more webpages on OHA’s website, including, without limitation, OHA’s Contract Reports Website.

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

“Related Party” means an entity that: (i) provides administrative services or financing to a coordinated care organization directly or through one or more unrelated parties; and (ii) is associated with the coordinated care organization by any form of affiliation, control or investment.

“Remittance Advice” and “RA” each have the meaning as provided in OAR 410-120-0000.

127. “Renew” “Renewal” and “Renewed” each means an agreement by ~~OHA~~ the Authority and Contractor to amend the terms or conditions of the Contract for the next ~~Benefit Period~~ Contract Year. “Renew” does not include expiration of the Contract followed by a successor contract.

128. “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” and “RFA” each have the meaning as provided in OAR 410-141-3010.

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

“Resident Abuse” means abuse of a resident of a facility as the terms abuse, resident, and facility are defined under ORS 441.357 (resident), ORS 441.630 (abuse), and ORS 442.015 (facility).

“Restricted Reserve Account” means a reserved sum of money in a segregate account that can only be used for specific purposes as set forth in Ex. L of this Contract

“Risk Accepting Entity” means an entity that: (i) enters into an arrangement or agreement with a coordinated care organization to provide health services to members of the coordinated care

organization; (ii) assumes the financial risk of providing health services to medical assistance recipients; and (iii) compensated on a prepaid capitated basis for providing health services to members of a coordinated care organization.

“Risk Adjusted Rate of Growth” means the percentage change in a CCO’s health care expenditures from one year to the next year, taking into account the variability in the relative health status of the members of the coordinated care organization from one year to the next year.

“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 Contractor is responsible for all adjusted expenses, OHA contributes a portion toward additional adjusted expenses, or receives a portion of lower adjusted expenses.

“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.

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

“SDOH-E Spending Programs Plan” means the plan detailing Contractor’s plan for spending funds on SDOH-E and provided to OHA as set forth in Sec. 8 of Ex. K of this Contract

“SDOH-E Spending Report” means that report required to be provided to OHA and identifies expenditures made during a particular Contract Year as set forth in Sec. 8 of Ex. K.

~~129. “SRTF” means Secure Residential Treatment Facility” and “SRTF” each means .~~

~~130. “Serious and Persistent Mental Illness” (and “SPMI) has” each have the meaning defined in OAR 309-036-0105.~~

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

“Service Authorization Request” has the meaning provided for in OAR 410-120-0000

“Service Authorization Handbook” means the written document that sets forth Contractor’s written Service Authorization Request policies and procedures.

~~131. “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.~~

~~132. —“Social Determinants of Health and Health Equity” or “SDOH HE” 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.~~

“Shelter Care” means a residential facility that meets the criteria set forth in OAR 410-170-0090 (1)(a) – (c)

“Significant Business Transaction” has the meaning provided in 42 CFR §455.01

“Skilled Nursing Facility” is a residential care facility that provides 24-hour a day care by registered nurses, licensed practical nurses, or nurse aids, and other health care professionals who provide medically necessary health care services and therapy to treat, manage, and observe a person’s condition, all of which is supervised by a physician and which must meet the requirements set forth in 42 CFR Part 483.

“Social Determinants of Health and Equity “SHOH-E” has the meaning provided in OAR 141-410-141-AAAA.

~~133.~~ **“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.

~~134.~~ **“State”** means the State of Oregon.

“State 1115 Waiver” means the 1115 Waiver issued to Oregon by CMS on or about January 12, 2017 for the period running through to June 30, 2022. 1115 waivers are issued by CMS in accordance with Section 1115 of the Social Security Act pursuant to which CMS waives federal guidelines relating to Medicaid in order to permit states, including Oregon to pilot and evaluate innovative approaches to serving Members.

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

~~135.~~ **“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.

“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.

~~136.~~ **“Subcontractor”** means any individual, entity, facility, or organization, other than a Participating Provider, that has entered into a ~~subcontract~~ Subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.

“Subcontractor Assignment Report” means the report required to be prepared by Contractor and submitted to OHA as set forth in Sec. 12, Ex. B, Part 4.

~~137.~~ **“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.

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

~~138.~~ **“Substance Use Disorders Provider”** means a Practitioner approved by OHA to provide Substance Use Disorders services.

~~139.~~ **“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.

“Supplier” has the meaning provided in 42 CFR 455.101

~~140.~~ **“Supported Employment Services”** means the same as “Individual Placement and Support (IPS) Supported Employment Services” as defined in OAR 309-019-0225.

~~141.~~ **“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 its 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 its 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.

~~142.~~ **“System of Care”** (and **“SOC”**) ~~each~~ 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.

~~143.~~ **“Team Facilitation”** means the process of working with the Child and Family Team in developing a unified plan of care.

“Term” means, in accordance with ORS 414.652(1)(a), the entire five years that Contractor is required to provide services to Members under this Contract commencing on January 1, 2020 and expiring, unless earlier terminated or otherwise not annually amended in accordance with its terms and conditions, December 31, 2024. Unless expressly stated otherwise, all terms and conditions of the Contract shall be applicable for its entire Term

“Third Party Liability” “Third Party Resource” or “Third Party Payer” have the meaning provided in OAR 410-120-0000. The acronyms, TPL, PPR, and TPP have the same definitions

“TOS Progress Report” means the annual progress report Contractor is required to submit to OHA on September 30 of each Contract Year in accordance with the requirements set forth under Sec. 2 of Ex. B, Part 10 of the Contract.

“TOS-OAPI Committee” means the committee required to be convened under Sec. 2 of Ex. B, Part 10 of the Contract and which is responsible for overseeing and approving Contractor’s annual TOS and annual TOS Progress Report.

“Trade Secrets” has the meaning provided in ORS 192.345

“Trading Partner” has the meaning provided in OAR 943-120-0100

~~144.~~ **“Traditional Health Worker”** (and **“THW”**) ~~has~~ each have the meaning defined in OAR 410-180-0305.

“Transformation and Quality Strategy” and “TOS” each means the deliverable related to Health System Transformation and Quality Assurance Performance Improvement which is required to be provided to OHA on March 15 of each Contract Year in accordance with Ex. B, Part 10 of the Contract.

~~145.~~ **“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 Coordinator” means the single point of contact, as identified by Contractor with whom OHA will work during the period that Contractor is executing its Transition Plan immediately preceding the expiration or termination of this Contract as provided for in Exhibit D of the Contract.

“Transition Period” means the period of time that Contractor is performing all of the tasks and activities required to be carried out under a Transition Plan.

“Transition Plan” is the plan required to be developed, written, and implemented by Contractor upon Contract expiration or termination as set forth in OAR 410-141-3258 and Exhibit D of this Contract.

~~146.~~ **“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.

~~147.~~ **“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.

“Tribal Organization” has the meaning set forth in Section 4 of the Indian Health Care Improvement Act and codified in 42 USC §1603.

~~148.~~ **“Tribes”** means Oregon’s nine federally recognized Tribes and, as the context requires, includes Oregon’s Urban Indian Health Program.

“Triple Aim” means the three goals of a Transformation and Quality Program as follows: (i) providing better care to Members, (ii) improving Member health, and (iii) doing so at a lower cost

“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” has the meaning set forth in Section 4 of the Indian Health Care Improvement Act and codified in 42 USC §1603.

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

“Usual Charge” and “UC” each have the meaning as provided in OAR 410-120-0000.

“Utilization Review” and “UR” each have the meaning as provided in OAR 410-120-0000.

~~149.~~ **“Valid Claim”** means a claim received by the Contractor for Payment of Covered and Non-covered Covered Services rendered to a Member which: (1) ~~Can~~ can be processed without obtaining additional information

from the Provider of the service; and (2) ~~Has~~has been received within the time limitations prescribed in ~~OHP Rules~~ OR 410-141-3420. 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).

~~150.~~ “Valid Encounter Data” means Encounter Data that ~~comply~~complies and is submitted in accordance with OAR 410-141-3430.

~~151.~~ “Value-Based Payment” ~~(and “VBP”) mean~~ each 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:

- ~~a.~~ Foundational Payments for Infrastructure and Operations;
- ~~b.~~ Pay for Reporting;
- ~~c.~~ Rewards for Performance/Penalties for Performance;
- ~~d.~~ Shared savings;
- ~~e.~~ Shared risk;
- ~~f.~~ Partial Capitation or Episode-based Payments;
- ~~g.~~ Comprehensive Population-based Payment; and
- ~~h.~~ Integrated Finance and Delivery System.

~~152.—“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.—~~

“Warm Handoff” has the meaning assigned to it under OAR 309-032-0860(30).

~~153.~~ “Waste” means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.

“Welcome Packet” means the materials required to be provided to new Members as set forth in OAR 410-141-3300(12).

“Wholly Owned Supplier” has the meaning provided in 42 CFR §455.101.

“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.

~~154.~~ “Withhold Month” means the month in which an APP will be applied to a Capitation Payment.

~~155.~~ “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.

~~156.~~ **“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:~~a.~~ Coordinating services such as access to Assessments and treatment services;~~b.~~ Coordinating services across the multitude of systems with which the Member is involved; and~~e.~~ Coordinating care with Child Welfare, the juvenile justice system and/or developmental disabilities system to meet placement needs.

~~157.~~ **“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.

~~158.~~ **“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.

~~159.~~ **“Year 1”** means 2020. Years 2 through 5 mean 2021 through 2024.

“Young Adult Peer Support” means a person who: (i) provides a youth or young adult with help, advice, guidance and support, (ii) has had similar experiences and lived similarly to the youth or young adult in need of the peer, and (iii) is in a unique position, based on similar experiences, to help the youth or young person navigate services, understand and communicate about treatment issues, and transition from utilizing the children’s mental health system to the adult mental health system. Youth or young adult in this instance refers to young people ages 14-25.

“Youth Development Council” means youth or young adult advisory and leadership groups that are young adult centric or led groups that provide input and advocacy on young adult mental health policy, programming and system development. Such groups are intended to empower young people to become advocates for themselves and others. It is also anticipated that such groups will provide vital feedback and information on the efficacy of mental health approaches, the impact of systems and services, and the elements necessary to providing responsive and developmentally appropriate mental health care and support for youth and young adults.

~~160.~~ **“Youth Partner”** has the same meaning as Youth Support Specialist ~~as defined in OAR 410-180-0305(22).~~

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

Document comparison by Workshare 10.0 on Friday, July 5, 2019 10:35:51 PM

Input:	
Document 1 ID	file://C:\Users\etaus\OneDrive\Desktop\JUSTICE-#9364624-v1 G-RFA_Appendix_A_Definitions.DOCX
Description	JUSTICE-#9364624-v1G-RFA_Appendix_A_Definitions
Document 2 ID	file://C:\Users\etaus\OneDrive\Documents\OREGON DOJ _ CCO Contract\FINAL DRAFT OF REASSEMBLED CONTRACT FOR JULY POSTING\Ex. A_Definitions_FINAL CLEAN_05 JULY 2019.DOCX
Description	Ex. A_Definitions_FINAL CLEAN_05 JULY 2019
Rendering set	Standard

Legend:	
Insertion	
Deletion	
Moved from	
Moved to	
Style change	
Format change	
Moved deletion	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	517
Deletions	452
Moved from	41
Moved to	41
Style change	0
Format changed	0
Total changes	1051

