OREGON HEALTH PLAN

Amended and Restated

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # «Contract_»-«Next_amend_»

with

«Registered_Name» «Registered_ABN»

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OREGON HEALTH PLAN
HEALTH PLAN SERVICES CONTRACT
COORDINATED CARE ORGANIZATION
GENERAL PROVISIONS

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

«Registered_Name», an Oregon «Entity_Type»
«Registered_ABN» with its principal place of business located at:

«Physical_AddressStreet»
«Physical_AddressCityStateZip»

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

The Contract, effective as of October 1, 2019, for coverage effective January 1, 2020, is hereby amended and restated in its entirety effective as of January 1, 2021 ("**2021 A&R Effective Date**"), regardless of the date of signature. The amendment and restatement of this Contract does not affect its terms and conditions for Work prior to the 2021 A&R Effective Date.

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

1. Annual Approval; Duration of Contract

Each Contract Year, this Contract, including the CCO Payment Rates contained herein, is subject to approval by the US Department of Health and Human Services (**"DHHS"** or "**HHS**"), Centers for Medicare and Medicaid Services ("**CMS**"). In the event CMS fails to approve the proposed 2021 CCO Payment Rates prior to the 2021 A&R Effective Date, OHA will pay Contractor at the proposed CCO Payment Rates and Contractor shall accept payment at the proposed CCO Payment Rates, subject to adjustment upon CMS approval or OHA modification of the CCO Payment Rates.

1.1. The Term of the CCO 2.0 Contract is five (5) years from its coverage effective date of January 1, 2020, unless terminated earlier as provided for in this Contract. This 2021 amended and restated Contract is Contract Year two of the five-year Term. Notwithstanding the foregoing, subject to ORS 414.590 (1)(b), the Contract may be amended every twelve (12) months upon expiration of each Contract Year. In the event Contractor is not in breach of this Contract at the end of a Contract Year, OHA will offer, subject

to (i) any amendments to the terms and conditions of this Contract and (ii) the applicable provisions of ORS 414.590, OAR 410-141-3700, and OAR 410-141-3725, to Renew this Contract for up to three additional, successive Contract Years following Contract Year two. In the event the Parties Renew this Contract for all additional Contract Years and is not earlier terminated in accordance with its terms, the expiration date of the Term of this Contract is December 31, 2024. Contract expiration, 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.

1.2. If Contractor declines to Renew this Contract for an additional Contract Year, Contractor shall provide OHA, in accordance with OAR 410-141-3725(2), with Legal Notice of its intention not to enter into the Contract Renewal no later than fourteen (14) days after Contractor's receipt of Administrative Notice of OHA's proposed amendments to the Contract for the subsequent Contract Year.

1.3. 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. Contract Administrators

2.1. Contractor designates:

«NamePrimary_CCO_contract_admin_per_Sec»
«Registered_Name» «Registered_ABN»
«Mailing_AddressStreetPOB»
«Mailing_AddressCityStateZip»
Phone: «PhonePrimary»
Fax: «FaxPrimary»
Email: «EmailPrimary»

as its Contract Administrator. Contractor shall provide OHA with Administrative Notice if its Contract Administrator or the associated contact information changes.

2.2. OHA designates:

Cheryl L. Henning
OHA HSD
500 Summer Street NE, E35
Salem, OR 97301
Phone: 503-593-6894
Fax: 503-378-8467
Email: Cheryl.L.Henning@dhsoha.state.or.us

as its Contract Administrator. OHA shall provide Contractor's Contract Administrator with Administrative Notice if OHA's Contract Administrator or the associated contact information changes.

3. Enrollment Limits and Service Area

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

[enter limit] [enter county and applicable zip codes]

[enter limit] [enter county and applicable zip codes]

[enter limit] [enter county and applicable zip codes]

3.2. 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. Entire Contract; Administration of Contract; Interpretation of Contract

4.1. Entire Contract

This Contract consists of the preamble and Sections 1 through 5 (**the "General Provisions"**), together with the following Exhibits and Exhibit attachments, and Reference Documents described in Section 4.1.1 below of these General Provisions 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 Payment
Exhibit I:	Grievance and Appeal System
Exhibit J:	Health Information Technology
Exhibit K:	Social Determinants of Health and Health Equity
Exhibit L:	Solvency Plan, Financial Reporting, and Sustainable Rate of Growth
Exhibit M:	Behavioral Health

*Exhibit C-Attachment 1 (CCO Payment Rates) and **Exhibit D-Attachment 1 (Deliverables and Required Notices) 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 Provisions and Exhibits A through M.

4.2. Administration of Contract

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 Parties shall comply with: (a) all Applicable Laws and regulations and (b) the terms and conditions of this Contract and all amendments thereto that are in effect on the Contract Effective Date or come into effect during the Term of this Contract. In 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 Provisions 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. These General Provisions of the Contract (without Exhibits, Exhibit attachments, or Reference Documents) over any Exhibits, Exhibit attachments, or Reference Documents.

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

i. Exhibit E: Required Federal Terms and Conditions

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, Financial Reporting, and Sustainable Rate of Growth

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

x. Exhibit K: Social Determinants of Health and Equity

xi. Exhibit J: Health Information Technology

xii. Exhibit H: Value Based Payment

xiii. Exhibit F: Insurance Requirements

4.3.1.3. This Contract (with Exhibits and Exhibit attachments) over any Reference Documents.

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 as the Exhibit 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 CHP 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 CHP 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 CHP 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. In the event that the Parties need to look outside of this Contract for interpreting its terms, the Parties shall consider only the sources in the list set forth below in this Section 4.3.2 of these General Provisions 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. The Oregon State Medicaid Plan and any grant award letters, waivers or other directives or permissions approved by CMS for operation of the Oregon Health Plan.

4.3.2.2. The Federal Medicaid Act, Title XIX of the Social Security Act, the Children's Health Insurance Program, 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. The Oregon Revised Statutes or other enacted Oregon Laws concerning the OHP.

4.3.2.4. The Oregon Administrative Rules promulgated by OHA and other OARs applicable to Medical Assistance Programs and health services prior to the Contract Effective Date, or subsequent amendments to the Contract, to implement OHP.

4.3.2.5. The OARs promulgated after the Contract Effective Date 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 law, changes in federal law or written guidance, or changes in OHA's OHP waivers or State plan.

4.3.3. 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 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 OHP, Contractor shall enter into any and all amendments to this Contract that are necessary to conform to those laws or regulations.

5. Contractor Data and Certification

Contractor Information. Contractor shall provide the information required as 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) below; and (ii) delivering, via Administrative Notice, a certificate of insurance as required under Ex. F, Sec. 10.

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. Certification and Acknowledgement

Without limiting the applicability of any other State or federal law, by signature on this Contract, Contractor hereby certifies and acknowledges that:

5.1.1. 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) Contractor and that pertains to this Contract.

5.1.1.1. No claim described in Section 5.1.1 above is or will be a "False Claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755.

5.1.1.2. In addition to the remedies under this Contract, if Contractor 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 Contractor.

5.1.2. 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.

5.1.2.1. 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. 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 after due inquiry for a period of no fewer than six (6) calendar years preceding the Contract 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. 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 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. The information shown in Section 5 of the General Provisions, "Contractor Data and Certification" is Contractor's true, accurate and correct information;

5.1.6. 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. 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. 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/SAM or such alternative system required for use by Medicaid programs.

5.1.9. 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. 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 Provisions is true and accurate. If this information changes, Contractor shall provide OHA with the new FEIN within ten (10) days of the date of change.

5.3. Signatures

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

«Registered_Name» «Registered_ABN»
By:

Authorized Signature	Printed Name
Title	Date

Reviewed and approved by Health Systems Division (HSD) Medicaid Unit
By:

David Inbody, CCO Operations Manager	Date

State of Oregon, acting by and through its Oregon Health Authority
By:

Margie C. Stanton, HSD Director	Date

Approved as to Legal Sufficiency:
Electronic approval by Theodore C. Falk, Senior Assistant Attorney General, Health and Human Services Section, on September 28, 2020; email in Contract file.

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) 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 Contract (including its Reference Documents and Report templates) shall have the meanings as provided when such terms are not listed below.

"21st Century Cures Act" and **"Cures Act"** each means the legislation that became effective in December, 2016 relating to, among other matters, interoperability, information blocking, and the Office of the National Coordination for Health Information Technology Certification Program.

"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.

"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.

"2021 A&R Effective Date" means the date on which this Contract became effective, as amended and restated for Contract Year two, which is January 1, 2021.

"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 within 63 days of the date of notification, applying the standard in OAR 410-141-3570 in effect for the Subject Month.

"AP Withhold" and **"Administrative Performance Withhold"** and **"AP Withhold"** and **"APW"** each means the dollar amount equal to one percent (1%) of 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.

"Abuse" has the meaning provided for in 42 CFR § 455.2.

"Actuarial Report" is defined in Sec. 7, Ex C. of this Contract.

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

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

"Acute Care Psychiatric Hospital" and "**ACPH**" each has the meaning provided for in OAR 309-019-0105..

"Adjudication" has the meaning provided in OAR 410-141-3500. 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" (also "**Administrative Notification**") means a notice from Contractor to OHA, or from OHA to Contractor, which is for purposes of administering the Contract and 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 Director of the Oregon Health Authority (OHA) or the Director's 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 183.484 pursuant to the procedures in OAR 137-004-0080 to 137-004-0092.

"Administrative Performance Penalty" and **"AP Penalty"** and **"APP"** each means the dollar amount equal to one percent (1%) of 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.

"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 provided for in OAR 410-141-3875.

"Affiliate" means a Person that directly, or indirectly through one or more intermediaries, Controls, or is Controlled by, or is under common Control with, the Person 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 has the meaning provided for in OAR 410-120-0000.

"All Plan System Technical Meeting(s)" and **"APST Meeting(s)"** each means those teleconference meetings for all CCOs, including Contractor, held by OHA for the purpose of addressing on-going business and technology system related issues as described in Ex. B, Part 9, Sec. 9, Para. b.

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

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

"Ambulatory Surgical Center" and **"ASC"** each has the meaning provided for in OAR 410-120-0000.

"American Indian/Alaska Native" and **"AI/AN"** each means any individual defined in 25 USC §§ 1603(13), 1603(28, or 1679(1) or who has been determined eligible as an Indian under 42 CFR § 136.12 or defined as Indian under 42 CFR § 438.14. "**Indian**" has the same meaning.

"Ancillary Services" has the meaning provided for 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 Health Equity Assessment Report" means the annual report regarding the status and assessment of Contractor's Health Equity Plan as described in Ex. K, Sec 10, Para e. of this Contract.

"Appeal" has the meaning provided for in OAR 410-141-3875.

"Applicable Law(s)" means all State and federal statutes, rules, regulations, and case law, as may be amended from time to time, applicable to a particular issue that is referenced in or applicable to this Contract.

"Applicant" has the meaning provided for in OAR 410-141-3700.

"Application" has the meaning provided for in OAR 410-141-3700.

"Area Agency on Aging" and **"AAA**" each has the meaning provided for in OAR 410-120-0000.

"Assertive Community Treatment" and **"ACT"** each has the meaning provided for in OAR 309-019-0105.

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

"Authority" means the Oregon Health Authority.

"Automated Voice Response" and **"AVR"** each has the meaning provided for in OAR 410-120-0000.

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

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

"Behavior Rehabilitation Services Program" has the meaning provided in OAR 410-170-0020(6).

"Behavioral Health" means the spectrum of behaviors and conditions comprising mental health, substance use disorders, and problem gambling.

"Behavioral Health Facility" means a facility or organization for the diagnosis or diagnosis and treatment of individuals in which care of a specialized nature is provided under the professional supervision of persons licensed to provide Behavioral Health care.

"Benchmark" for each Incentive Measure means the statewide benchmark published at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx for the Incentive Measure for the Measurement Year, subject to change by the Metrics and Scoring Committee.

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

"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 410-200-0400 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 provided for in OAR 410-141-3500.

"Capitation Payment" has the meaning provided for in OAR 410-141-3500.

"**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 provided for in OAR 410-141-3500.

"CCO Payment Rates" means the rates for CCO Payments to Contractor as set forth in Exhibit C-Attachment 1 of the Contract.

"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 Contractor is responsible for all of its adjusted expenses, OHA contributes a portion toward additional adjusted expenses or receives a portion of lower adjusted expenses.

"Care Coordinator" is a single, consistent individual who: (i) is familiar with (a) a Member's history, strengths, needs, support system, Providers, and legal status, and (b) the systems with which a Member is involved; (ii) follows a Member through transitions in levels of care; (iii) is responsible for taking a system-wide view to ensure services are unduplicated and consistent with the Member's identified strengths and needs; (iv) is responsible for ensuring that participants involved in a Member's Care Coordination facilitate the appropriate health care services and support activities; and (v) fulfills the Care Coordination standards identified in this Contract.

"Care Coordination" means the organized coordination of a Member's health care services and support activities and resources. The coordination occurs between and among two or more participants deemed responsible for the Member's health outcomes and includes, at minimum, the Member (and their Family/caregiver as appropriate) and the Member's assigned Care Coordinator. Organizing and facilitating the appropriate delivery of health care services, supports, and resources involves a team-based approach focused on the needs and strengths of the individual Member. Successful Care Coordination requires the exchange of information among Care Coordinating participants, explicit assignments for the functions of specific Care Coordinating participants, and addresses the Member's interrelated and interdependent 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 a Member's 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 the Member. Care Coordination contributes to a patient-centered, high-value, high-quality care system.

"Carve-Out Services" means services that are not covered under this Contract but are provided by OHA or by a third party contracted by OHA.

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

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

"Centers for Medicare and Medicaid Services" 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.

"**Certified Health Care Interpreter**" has the meaning provided for in ORS 413.550.

"**Child Abuse**" is Abuse of a Child as the terms Abuse and Child are defined under ORS 419B.005.

"Child and Family Team" means a group of people, chosen by the Family and connected to them through natural, Community, and formal support relationships, and representatives of child-serving agencies who are serving the child and Family, who will work together to develop and implement the Family's plan, address unmet needs, and work toward the Family's vision.

"Child Welfare" and **"CW"** each has the meaning provided for in OAR 410-120-0000.

"Children's Health Insurance Program" and **"CHIP"** each has the meaning provided for in OAR 410-120-0000.

"Citizen/Alien Waived Emergency Medical" and **"CAWEM"** each has the meaning provided for in OAR 410-120-0000.

"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(s) as such term is defined in ORS 426.005(1)(a).

"Claimant" has the meaning provided for in OAR 410-120-0000.

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

"Client" means an individual found eligible to receive OHP health services, whether or not the individual is enrolled as an MCE Member.

"Clinical Record" has the meaning provided for in OAR 410-120-0000.

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

"CMS Interoperability and Patient Access Final Rule" means the new and amended federal regulations, effective as of June 30, 2020, set forth in 42 CFR Parts 406, 407, 422, 423, 431, 438, 457, 482 and 485, which were authorized and adopted pursuant to the 21st Century Cures Act and Executive Order 13813. The CMS Interoperability and Patient Access Final Rule was published in the Federal Register with the heading "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers" in Volume 85, No. 85, 25510 through 25640, May 1, 2020. The CMS Interoperability and Patient Access final rule can be found at the following URL: https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

"Cold Call Marketing" has the meaning provided for in OAR 410-141-3575.

"Collaborative CHA/CHP Partners" has the meaning provided for in OAR 410-141-3730(1).

"Community" has the meaning provided for in ORS 414.018(5)(a).

"Community Advisory Council" and **"CAC"** each has the meaning provided for in OAR 410-141-3500.

"**Community-Benefit Initiative**" is a type of Health-Related Service and has the meaning provided in OAR 410-141-3500.

"Community Health Assessment" and "**CHA**" each 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"** each 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 identifying 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 provided for in OAR 410-120-0000.

"Community Mental Health Program" and **"CMHP"** each has the meaning provided for in OAR 410-120-0000.

"Community Standard" means typical expectations for access to the health care delivery system in the Member's community of residence. Except where the community standard is less than sufficient to ensure quality of care, OHA requires that the health care delivery system available to Division members in MCEs take into consideration the community standard and be adequate to meet the needs of OHA's enrollment.

"Compliance Status Agreement" means that agreement that may be entered into by Contractor and OHA as set forth in Exhibit B, Part 8, Section 9 of this Contract.

"Comprehensive Behavioral Health Plan" and **"CBH Plan"** each means the Behavioral Health Plan that meets the criteria set forth in ORS 430.630(9)(b) and Sec. 12 of Ex. M of this Contract.

"Condition/Treatment Pairs" means a health service being provided to treat a medical/behavioral health/oral health disease, disorder or injury, or to prevent a condition for which a person could be at risk, which when coded and paired together on a billing claim form, may or may not be Covered Service depending on how such treatments and conditions fall within HERC's Prioritized List of Health Services. HERC's Prioritized list of Health Services indicates which Condition/Treatment Pairs are Covered Services and is located at the following URL: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

"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.

"Contested Case Hearing" has the meaning provided for in OAR 410-141-3875.

"Continuity of Care" has the meaning provided for in OAR 410-141-3810.

"Contract" means the General Provisions together with all Exhibits, Exhibit attachments, and Reference Documents as set forth in Section 4 of the General Provisions, and any amendments (including restatements) thereto.

"Contract Administrator" means either Contractor's or OHA's staff member who is the point person 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 this Contract became effective, which was October 1, 2019, and as identified in Section 1 of the General Provisions of this Contract.

"Contract Health Services" and **"CHS"** each means a federal funding source designed to provide specialty care services to eligible American Indians and Alaska Natives 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.

"Contractor" means an Applicant selected through RFA OHA-4690-19 and is the party that entered into this Contract with OHA.

"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. OHA shall presume that a Person controls another Person if the Person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of the other Person.

"Coordinated Care Organization" and **"CCO"** each has the meaning provided for in OAR 410-141-3500.

"Coordinated Care Services" has the meaning provided for in OAR 410-141-3500.

"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 provided for in OAR 410-120-0000.

"Corrective Action" and **"Corrective Action Plan"** each has the meaning provided for in OAR 410-141-3500.

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

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

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

"COVID-19 Emergency" means the period:

(i) Starting on the earliest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by OHA; and

(ii) Ending on the latest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by OHA. OHA will publish guidance on the CCO Contracts Website regarding the duration of the COVID-19 Emergency.

"Cultural Competence" has the meaning provided for in OAR 943-090-0010. Operationally defined, Cultural Competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.

"**Culturally and Linguistically Appropriate**" and "**CLAS**" each 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. 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 provided for in OAR 410-120-0000.

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

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

"Delegate" means the act of Contractor assigning Work to either (i) a Subcontractor under a Subcontract, or (ii) a governmental entity or agency pursuant to a Memorandum of Understanding.

"Dental Care Organization" and **"DCO"** each has the meaning provided for in OAR 410-141-3500.

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

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

"Department of Consumer and Business Services" and **"DCBS"** each has the meaning provided for in OAR 410-141-3500.

"Department of Human Services" and **"DHS"** each has the meaning provided for in OAR 410-120-0000.

"Diagnosis Related Group" and **"DRG"** each has the meaning provided for in OAR 410-120-0000.

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

"Discover" means the first day on which Contractor knows an event has occurred, or, by exercising reasonable diligence, Contractor would have been known that an event had occurred.

"Disenrollment" has the meaning provided for in OAR 410-141-3500.

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

"Drug Utilization Review Program" and **"DUR Program"** each means the drug utilization review program that complies with 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**" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose.

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

"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.

"**Elder Abuse**" is abuse of an elderly person with or without disabilities as the terms Abuse and Elderly Person are defined ORS 124.050.

"Electronic Data Transaction" and **"EDT"** each has the meaning provided in OAR 943-120-0100(21).

"Electronic Data Transaction Rules" and **"EDT Rules"** each means the requirements specified in OAR 943-120-0100 through 943-120-0200 applicable to entities, including CCOs, that conduct electronic data transactions with OHA.

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

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

"Emergency Department" and **"ED"** each has the meaning provided for in OAR 410-120-0000.

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

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

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

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

"Encounter Data" means certain information required to be submitted to OHA under OAR 410-141-3570 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.

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

"Enrollment" has the meaning provided for in OAR 410-141-3500.

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

"**Excluded Services**" means those services that Contractor is not required to provide to Members under this Contract.

"Expiration Date" means the date the Term of this Contract expires, which is December 31, 2024, as identified in Section 1.1 of the General Provisions.

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

"External Quality Review" and "**EQR**" each 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.

"False Claim" has the meaning provided for in OAR 410-120-0000. See also Oregon False Claims Act as set forth in ORS 180.750-180.785 and federal False Claims Act as set forth in 31 USC 3729 through 3733.

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

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

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

"Federally Qualified Health Center" and **"FQHC"** each has the meaning provided for 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.

"Fidelity" means the extent to which a program adheres to the applicable 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:

- **(i)** adherence to the core values and principles of Wraparound care planning processes and supports;
- **(ii)** whether the basic activities of facilitating a Wraparound process are occurring; and
- **(iii)** supports at the organizational and system level.

"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.

"Flexible Service" is a type of Health-Related Service which are Cost-Effective services offered to an individual Member to supplement Covered Services.

"Four Quadrant Clinical Integration Model" means a model of health care that describes levels of integration in terms of primary care complexity and risk and mental health/Substance Use Disorder complexity and risk. The location, types of providers, and services will depend on the complexity of a patient's conditions.

"Fraud" means the intentional deception or misrepresentation that Person 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 themselves or some other Person(s).

"FWA Prevention Handbook" means the handbook of Fraud, Waste, and Abuse policies and procedures that complies with the requirements set forth in Sec. 11 of Ex. B, Part 9 and any other applicable provisions of this Contract.

"Fully Dual Eligible" and **"Full Benefit Dual Eligible"** and **"FBDE"** each has the meaning provided for in OAR 410-120-0000.

"Global Budget" has the meaning provided for in OAR 410-141-3500.

"Governance Structure" and **"Governing Board"** each means Contractor's governing body that meets the requirements of ORS 414.572.

"Grievance" has the meaning provided for in OAR 410-141-3875.

"Grievance and Appeal System" has the meaning provided for "Grievance System" in OAR 410-141-3500.

"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 CCO Contract Forms Website

"Ground Emergency Medical Transportation Services" and **"GEMT Services"** each means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by eligible GEMT providers before or during the act of transportation.

"Habilitation Services and Devices" means those health care services and devices that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

"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 ("**EDIE**")/PreManage and Oregon Prescription Drug Monitoring Program (PDMP) Integration.

"Home and Community-Based Services" and **"HCBS"** each means, as provided for in the definition of "Medicaid-Funded Long-Term Services and Supports" in OAR 410-141-3500, the Medicaid services and supports provided under a CMS-approved waiver to avoid institutionalization as defined in OAR Chapter 411,

Division 4 and defined as Home and Community-Based Services (HCBS) and as outlined in OAR Chapter 410, Division 172, Medicaid Payment for Behavioral Health Services.

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

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

"Health Equity" and **"HE"** each means a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all sectors across Oregon, including Tribal governments, to address the equitable distribution or redistributing of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices.

"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"** each has the meaning provided for in OAR 410-120-0000.

"Health Information Exchange" and **"HIE"** each means the electronic movement of health information among disparate organizations and Health Information Systems.

"Health Information System" and **"HIS"** each means information technology systems that meet the requirements set forth in 42 CFR § 438.242 and Section 1903(r)(1)(F) of the Patient Protection Affordable Care Act of 2010 as amended from time to time.

"Health Information Technology" and **"HIT"** each 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" has the meaning provided in ORS 731.162.

"Health Insurance Portability and Accountability Act" and **"HIPAA"** each has the meaning provided for in OAR 410-120-0000.

"Health System Transformation" has the meaning provided in OAR 410-141-3500.

"Healthcare Common Procedure Coding System" and **"HCPCS"** each has the meaning provided for in OAR 410-120-0000.

"**Healthcare Payment Learning and Action Network**" and "**LAN**" each means the public private partnership whose mission is to 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 FFS payment model to a model that pays providers for quality care, improved health, and lower costs. The partnership was launched in 2015 by HHS.

"Health-Related Services" and "HRS" each has the meaning provided for in OAR 410-141-3500 and described in OAR 410-141-3845.

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

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

"Hepatitis C DAA Revenue" means an amount included in the Hepatitis C DAA adjustment specified in the CCO Payment 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, 2021, through December 31, 2021.

"Holistic Care" has the meaning provided for in OAR 410-141-3500.

"Home Health Care" means part-time or intermittent skilled nursing services, other therapeutic services (including, without limitation, physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the Member's home.

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

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

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

"Hospital Outpatient Care" means services that are furnished in a Hospital for the care and treatment of an Outpatient (as such term is defined below in this Exhibit A).

"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).

"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: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx) by which Contractor's performance on each Incentive Measure is to improve during the Measurement Year by comparison with the Baseline.

"Incentive Measures" means the Quality Measures specified by OHA for a Measurement Year, subject to change by the Metrics and Scoring Committee and CMS approval.

"Indian" has the same meaning as American Indian/Alaska Native as defined above in this Exhibit A.

"Indian Health Care Provider" and **"IHCP"** each has the meaning provided for in OAR 410-141-3500.

"Indian Health Service" and **"IHS"** each has the meaning provided for in OAR 410-120-0000.

"Individualized Management Plan" means a detailed plan for contacting and offering services (including Health-Related Services) to all Members who are admitted to either: (i) the Emergency Department two or more times in a six-month period for a psychiatric reason, or (ii) an Acute Care Psychiatric Hospital two or more times in a six-month period (each an "**IMP Member**"). Its purpose is two-fold: (x) to avoid unnecessary readmissions to Emergency Departments and Acute Care Psychiatric Hospitals and (y) to better address the needs of these IMP Members in settings other than institutional settings. All Individualized Management Plans shall include, without limitation, all of the following:

- **(i)** Identification of the Medicaid and non-Medicaid services necessary to effectively address the needs of the IMP Member;
- **(ii)** A plan for providing the necessary Medicaid and non-Medicaid services to the IMP Member;
- **(iii)** Identification of the IMP Member's housing needs;
- **(iv)** A plan for assisting the IMP Member with accessing agency and Community resources that will assist with identifying and obtaining housing that will enable such Member to meet their treatment goals, clinical needs, and informed choice; and
- **(v)** The name and title of the individual who is responsible for ensuring the IMP Member's Individual Management Plan is implemented and completed (i.e., treatment and all services, including housing and other Health-Related Services are received, effective, and completed).

"Individual Service and Support Plan" and **"ISSP"** each means a comprehensive plan for services and supports provided to or coordinated for a Member that is reflective of the intended outcomes of service.

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

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

"Intensive In-Home Behavioral Health Treatment" and **"IIBHT"** each has the meaning provided for in OAR 309-019-0167.

"Intensive Care Coordination" and **"ICC"** each has the meaning provided for in OAR 410-141-3500.

"Intensive Care Coordinator" means a Person providing "Intensive Care Coordination" services defined in OAR 410-141-3870.

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

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

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

"Intensive Treatment Services" and **"ITS"** each 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.

"Invoiced Rebate Dispute" means a disagreement between a pharmaceutical manufacturer and Contractor regarding the dispensing of pharmaceuticals, as submitted by OHA to Contractor through the process set forth in Exhibit B, Part 8 of this Contract.

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

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

"Learning Collaborative" means a program in which CCOs, State agencies, and PCPCHs that provide or perform the activities that serve Health System Transformation objectives, achieve, the purposes of the Contract, and share:

- **(i)** information about Quality Improvement;
- **(ii)** best practices about methods to change payment to pay for quality and performance;
- **(iii)** best practices and emerging practices that increase access to Culturally and Linguistically Appropriate care and reduce health disparities;
- **(iv)** best practices that increase the adoption and use of the latest techniques in effective and Cost Effective patient centered care;
- **(v)** information to coordinate efforts to develop and test methods to align financial incentives to support PCPCHs;
- **(vi)** 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;
- **(vii)** best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services;
- **(viii)** information and best practices on the use of Health-Related Services; and
- **(ix)** information and best practices on Member engagement, education and communication.

"Legal Notice" means a notice from OHA to Contractor, or from Contractor to OHA, as described in and pursuant to the requirements set forth in Exhibit D, Section 26, Paragraph a. of this Contract.

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

"Licensed Health Entity" has the meaning provided for in OAR 410-141-3500.

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

Practitioner, or Physician Assistant, who is licensed to practice in the State of Oregon, and whose training, experience and competence demonstrate the ability to conduct a Mental Health Assessment and provide medication management; or for Intensive Outpatient Services and Support (IOSS) and Intensive Treatment Services (ITS) Providers, a board-certified or board-eligible child and adolescent Psychiatrist licensed to practice in the State of Oregon per OAR 309-019-010543F4

"**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 means any one of the following entities:

(i) the board of county commissioners or one or more counites that establishes or operates a CMHP;
(ii) the tribal council in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide Behavioral Health services; or
(iii) a regional local mental health authority composed of two or more boards of county commissioners.

"Long-term Care" has the meaning provided for in OAR 410-141-3500.

"Long Term Psychiatric Care" 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.

"Managed Care Entity" and **"MCE"** each has the meaning provided for in OAR 141-410-3500.

"Managing Employee" has the meaning provided in 42 CFR § 455.101.

"Marketing" has the meaning provided for in OAR 410-141-3575.

"Marketing Materials" has the meaning provided for in OAR 410-141-3575.

"Measurement Year" means the preceding calendar year.

"Medicaid" has the meaning provided for in OAR 410-120-0000.

"**Medicaid-Funded Long Term Services and Supports**" and "**LTSS**" each has the meaning provided for in OAR 410-141-3500.

"Medical Assistance Program" has the meaning provided for in OAR 410-120-0000.

"Medical Facility" has the meaning provided for in 42 CFR § 124.2.

"Medical Loss Ratio" and **"MLR"** each means the proportion of premium revenues (net of taxes) spent on incurred claims, including Provider Stabilization Payments, quality health improvements, and fraud prevention activities.

"Medical Services" has the meaning provided for in OAR 410-120-0000.

"Medically Appropriate" has the meaning provided for in OAR 410-120-0000.

"**Medically Necessary**" has the meaning provided for in OAR 410-120-0000.

"Medicare" has the meaning provided for 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.

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

"Member" means a Client who is enrolled with Contractor under the Contract.

"Member Handbook" means the handbook that includes all of the information and documentation required under both 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.

"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:

- **(i)** 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),
- **(ii)** a spouse, or other Family member as designated by the Member, the Individual Service Plan Team (for Members with developmental disabilities),
- **(iii)** a parent or legal guardian of a minor below the age of consent,
- **(iv)** a DHS or OHA case manager or other DHS or OHA designee. For Members in the care or custody of DHS Children, Adults, and Families (CAF) or OYA, the Member Representative is DHS or OYA. For Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the Member Representative is their parent or legal guardian.

"**Memorandum of Understanding**" and **"MOU"** each means an agreement between Contractor and a governmental agency or entity pursuant to which such agency or entity performs Work under this Contract on behalf of or as otherwise requested by Contractor.

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

"**MMLR**" means the minimum MLR required to be met by Contractor in accordance with the terms and conditions of this Contract.

"MMLR Rebate Period" means:

- **(i)** for 2020, Contract Year 1, and
- **(ii)** for later years, a cumulative rolling three-year reporting period of three consecutive Contract Years, starting with the 2021-2023 reporting period.

"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 MMLR Rebate Period, would result in an MMLR equal to the MMLR Standard. If Contractor's MMLR for the MMLR Rebate Period exceeds the MMLR Standard, the Rebate is zero.

"MMLR Standard" means an MMLR of 85% times a ratio for Contractor's total Member population. For Contract Year one (2020), the ratio is 1.0. For subsequent Contract Years, the ratio is 1.0 plus the Quality Pool and Challenge Pool distributions received by Contractor for that Contract Year, divided by the CCO Payments for that Contract Year used to determine the available amount of Quality Pool distributions for Contractor in that Contract Year. OHA will provide details on the calculation of the ratio and its application to the MMLR Rebate Period in the MMLR Rebate Report and associated Instructions described in Sec 10, Ex. C.

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

"**Monitor**" means:

- **(i)** to observe and check the progress or quality of something,
- **(ii)** to 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.

"**NAIC**" means National Association of Insurance Commissioners and has the meaning provided for in OAR 410-141-3500.

"NQTL" means Non-quantitative treatment limitation.

"National Correct Coding Initiative" and **"NCCI"** each has the meaning provided for in OAR 410-120-0000.

"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 reports 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 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

"Neuropsychiatric Treatment Service" and **"NTS"** each means the four units at a 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 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, Part 8 of this Contract.

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

"Non-Emergent Medical Transportation Services" and **"NEMT"** each has the meaning provided for in OAR 410-120-0000.

"Non-Participating Provider" has the meaning provided for in OAR 410-141-3500.

"Non-Pharmacy Encounter Data" means institutional and Dental encounter claims that are required to be submitted to OHA under OAR 410-141-3570 and OAR 943-120-0100 through 943-120-0200.

"Notice of Adverse Benefit Determination" and **"NOABD"** each has the meaning provided for in OAR 410-141-3875.

"Notice of Appeal Resolution" means Contractor's notification to a Member of the resolution of an Appeal described in OAR 410-141-3890.

"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 provided for in OAR 410-120-0000.

"OHP" means Oregon Health Plan and has the meaning provided for in OAR 410-141-3500.

"OHPB" means the Oregon Health Policy Board.

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

"ONC 21st Century Cures Act Final Rule" means the new and amended federal regulations, effective as of June 30, 2020, set forth in 45 CFR Parts 170 and 171, which were authorized and adopted pursuant to the 21st Century Cures Act. The ONC 21st Century Cures Act Final Rule was published in the Federal Register with the heading "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" in Volume 85, No. 85, 25642 through 25691, May 1, 2020. The ONC 21st Century Cures Act Final Rule can be found at the following URL: https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification.

"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 for in OAR 410-141-3500.

"Oral Health Provider" means a Provider who provides Oral Health services.

"Oregon Health Authority" and **"OHA"** each has the meaning provided for in OAR 410-120-0000.

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

"Other Disclosing Entity" has the meaning provided for 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, automobile 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 provided for in 42 CFR § 447.26(b).

"Outpatient" means a patient of an organized medical facility or behavioral health facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

"Outpatient Behavioral Health Services" means Behavioral Health services delivered on an Outpatient basis.

"Outreach" has the meaning provided for in OAR 410-141-3575.

"Overpayment" has the meaning provided for in 42 CFR § 438.2.

"**Over-Performance**" means the difference between (i) the aggregate of all rates and fees Contractor actually paid to its PBM for all claims and (ii) the aggregate guarantee for all contracted rates and fees agreed to in the PBM Subcontract entered into by and between Contractor and its PBM.

"Ownership Interest" has the meaning provided for in 42 CFR §455.101.

"Participating Provider" has the meaning provided for in OAR 410-141-3500.

"Patient Protection and Affordable Care Act" and **"PPACA"** and **"ACA"** 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).

"Patient-Centered Primary Care Home" 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.

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

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

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

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

"Peer-Delivered Services" and **"PDS"** each has the meaning provided for 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 affect Member rights or health, or
(iv) any combination of or all of the forgoing issues. One or more Performance Issue(s) 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 governmental agency but excluding federal agencies, federal courts, and the State courts. See 42 CFR § 401.102. When the term "person" is used in the lower case, such term means an individual human being.

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

"Personal Injury Lien" and **"PIL"** each 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.

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

"Pharmacy Benefit Manager" and **"PBM"** each 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 410-141-3570.

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

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

"Physician Incentive Plan" means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to a Member.

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

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

"Potential Member" has the meaning provided for in OAR 410-141-3500.

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

"Predecessor CCO Contract" and "**Predecessor Contract**" each means a contract entered into by Contractor and OHA for the same or similar services as those provided under this Contract which was awarded to Contractor in response to RFA # 3402 and expired on December 31, 2019.

"Preferred Drug List" and **"PDL"** each 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 410-141-3855.

"Prepaid Health Plan" and **"PHP"** each means has the meaning provided for in OAR 410-120-0000.

"Primary Care Provider" and **"PCP"** each has the meaning provided for in OAR 410-141-3500.

"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).

"Premium" means the fee charged by, and which is required to be paid to, a Health Insurance company or other health benefit plan in order to obtain Health Insurance or other health benefit coverage.

"Prescription Drug Coverage" means Prescription Drugs that are covered under this Contract.

"Prescription Drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or health maintenance that are:

(i) Prescribed by a Physician or other licensed practitioner of the healing arts within the scope of professional practice as defined and limited by the applicable license;
(ii) Dispensed by licensed pharmacists and licensed, authorized practitioners in accordance with the applicable licensing agency; and
(iii) Dispensed pursuant to a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

"Prior Authorization" and **"PA"** each has the meaning provided for in OAR 410-120-0000.

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

"Prioritized Populations" has the meaning provided for in OAR 410-141-3870.

"**Proposed SMED Report**" means that proposed Subject Month Encounter Data Report described in Ex. B, Part 8, Section 13 of the Contract.

"**Protected Information**" means all forms of personally identifiable client, Member, or patient information that are made confidential or privileged by State and federal law, and thus are prohibited from disclosure. The types of records and information covered, and the federal and State laws that apply to this definition may include, but are not limited to, the following:

- **(i)** Personal health information as defined and protected under 42 USC §§ 1320d to 1320d-9, 45 CFR parts 160 to 164, ORS 192.553 to 192.581, and ORS 179.505 to ORS 179.507;
- **(ii)** Drug and alcohol records as defined and protected under 42 USC § 290dd-2, 42 CFR part 2, and ORS430.399(6);
- **(iii)** Genetic information as defined and protected under ORS 192.531 to 192.549;
- **(iv)** Communicable disease information as defined and protected under ORS 433.008 and ORS 433.045(4);
- **(v)** Medical assistance records as defined and protected under 42 USC § 1396a(a)(7), 42 CFR § 431.300 to 431.307, and ORS 413.175;
- **(vi)** Other personal information as defined and protected under ORS 646A.600 to 646A.628;
- **(vii)** Educational records protected under FERPA and those protected under the Individuals with Disabilities Education Act;
- **(viii)** Child welfare records, files, papers, and communications provided for under ORS 409.225;
- **(ix)** Abuse records of adults with disabilities or mental illness provided for under ORS 430.763;
- **(x)** Elder abuse records and reports and any compilation thereof in accordance with ORS 124.090; and
- **(xi)** Privileged communications as set forth under ORS 40.225 through ORS 40.295.

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

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

"Provider Network" and **"Delivery System Network"** and **"DSN"** each means the entirety of those Participating Providers who are employed by or Subcontracted with Contractor for the purposes of providing services to Members.

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

"Provider Stabilization Payment" means any payment, including Value Based Payments, from Contractor to a Provider that is:

- **(i)** Made during a COVID-19 Emergency;
- **(ii)** When combined with any other payments to the Provider made for Covered Services rendered during the period, no greater than a reasonable estimate (based on historic claims data) of the claims the Provider would have submitted to Contractor for Covered Services provided to Members under this Contract but for the COVID-19 pandemic; and
- **(iii)** Made to ensure the availability of the Provider, both during and after any COVID-19 Emergency, to deliver Covered Services to Members under this Contract.

"Provider Termination" means the termination of Provider's contract with Contractor, or a prohibition of Provider's participation in OHA Health Services Division programs provided for by OAR 410-120-0000(241).

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

"Psychiatric Residential Treatment Service" and **"PRTS"** each has the meaning provided for in OAR 309-022-0105.

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

"Qualified Mental Health Associate" and **"QMHA"** each has the meaning provided for in OAR 309-019-0105.

"**Qualified Health Care Interpreter**" has the meaning provided for in ORS 413.550.

"Qualified Mental Health Professional" and **"QMHP"** each has the meaning provided for 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 410-141-3525.

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

"**Quality Improvement 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 TQS and annual TQS Progress Report.

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

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

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

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

"Receiving CCO" and **"Receiving Contractor"** each means the CCO that is receiving Members during the Open Enrollment period who were previously enrolled with another CCO.

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

"Records" means 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 written form, that are pertinent to this Contract.

"Recoup" and **"Recoupment"** each means the withholding by OHA of all or a portion of one or more future payments that may be owing to Contractor or a third-party to setoff amounts that are owing to OHA.

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

"**Reference Document**" and "**Guidance Document**" each means:

(i) those report templates, reference documents, guidance 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 CCO Contract Forms Website.

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

"Rehabilitation Services and Devices" means those health care services and devices that help Members keep, get back, or improve skills and functioning for daily living that have been lost or impaired because they were sick, hurt, or disabled. These services may include, without limitation, physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

"Related Party" means an entity that:

(i) provides administrative services or financing to a CCO directly or through one or more unrelated parties; and

(ii) is associated with the CCO by any form of affiliation, control or investment.

"Remittance Advice" and "RA" each has the meaning provided for in OAR 410-120-0000.

"Renew" and **"Renewal"** and **"Renewed"** each means an agreement by the Authority and Contractor to amend the terms or conditions of the Contract for the next Contract Year. "Renew" does not include expiration of this Contract on December 31, 2024, followed by a successor contract.

"Renewal Contract" means an amended and restated CCO Contract for the next Benefit Period that OHA submits to CMS for approval as described in OAR 410-141-3725.

"Report" means a document identified in Exhibit D-Attachment 1 (Deliverables and Required Notices) as a report.

"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 individual within the meaning provided by OAR 410-120-0000.

"Request for Applications" and **"RFA"** each has the meaning provided for in OAR 410-141-3700.

"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) Is 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 of 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 provided for in OAR 410-120-0000.

"Rural Health Center" has the same meaning as "rural health clinic" which is defined under Section 1905(l)(1) of the Social Security Act.

"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 provided for in OAR 410-120-0000.

"SDOH-E Partner" has the meaning provided for in OAR 410-141-3735.

"Serious and Persistent Mental Illness" and **"SPMI"** each has the meaning provided for in OAR 309-036-0105.

"Service Area" has the meaning provided for in OAR 410-141-3500.

"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 in accordance with Exhibit B, Part 2, Section 3 of this Contract.

"SHARE Initiative" means the SDOH-E spending program as described in Sec. 8 of Ex. K of this Contract.

"SHARE 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 of this Contract.

"Significant Business Transaction" has the meaning provided for in 42 CFR § 455.101

"Skilled Nursing Facility" is a residential care facility that provides 24-hour a day care by registered nurses, licensed practical nurses, or nurse aides, 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" and **"SDOH-E"** each has the meaning provided for in OAR 410-141-3735.

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

- **(i)** have functional disabilities,
- **(ii)** 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
- **(iii)** are a Member of the Prioritized Populations listed in the Contract.

"Specialist" means a Provider who has an area of expertise and who has completed advanced education and training beyond the minimum education and training required to be licensed in their profession. For example, Physician specialties include, without limitation, allergists, neurologists, endocrinologists, and cardiologists. Counseling specialties include, without limitation, substance abuse, educational, marriage and family, grief, art therapy. Physical Therapy specialties include, without limitation, cardiovascular and pulmonary, clinical electrophysiology, geriatrics, neurology, oncology, orthopedics, pediatrics, and sports.

"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 ending 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 1115 Waiver" does not include any waiver issued to Oregon by CMS specifically relating to the COVID-19 Emergency.

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

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

"Subcontract" has the meaning provided for in OAR 410-141-3500.

"Subcontractor" has the meaning provided for in OAR 410-141-3500.

"Subcontractor and Delegated Work Report" means the Report required to be prepared by Contractor and submitted to OHA as set forth in Sec. 11, Ex. B, Part 4.

"Subject Month" means the month in which the Date of Service occurred that is under review for timely and accurate Encounter Data submission using the AP Standard.

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

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

"Substance Use Disorder(s)" and **"SUD(s)"** each 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.

"Supplier" has the meaning provided for in 42 CFR 455.101.

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

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

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

"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, SUD treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is Culturally and Linguistically Appropriate 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.

"Term" means, in accordance with ORS 414.590(2)(a), the entire five year Term that Contractor is required to provide services to Members under this Contract commencing on January 1, 2020, and expiring, unless earlier terminated or not Renewed in accordance with Section 1.1 of the General Provisions and as otherwise provided for in this Contract, December 31, 2024. Unless expressly stated otherwise, all terms and conditions of the Contract shall be applicable for its entire Term.

"**Therapeutic Abortion**" means an abortion that, if and when performed, is performed because:

(1) The pregnancy is the result of an act of rape or incest; or
(2) The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a Physician, place the woman in danger of death unless an abortion is performed.

"Third Party Liability" and **"Third Party Resource"** and **"Third Party Payer"** and **"TPL"** and **"TPR"** and **"TPP"** each has the meaning provided in OAR 410-120-0000.

"TQS 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.

"Trade Secrets" has the meaning provided in ORS 192.345. A Trade Secret may include, without limitation, the method or dollar parameters for determining compensation paid to Providers.

"Trading Partner" has the meaning provided in OAR 943-120-0100.

"Traditional Health Worker" and **"THW"** each has the meaning defined in OAR 410-180-0305.

"Transformation and Quality Strategy" and **"TQS"** 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.

"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 410-141-3710 and Exhibit D of this Contract.

"Transferring CCO" means a CCO that is transferring Members during the Open Enrollment period to another CCO because of contract termination, Member choice, or auto -assignment.

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

"Treatment Plan" has the meaning provided for in OAR 410-141-3500.

"Tribal Advisory Council" and **"TAC"** each has the meaning provided for in ORS 414.581.

"Tribal Liaison" means the tribal liaison described in ORS 414.572.

"Tribal Organization" has the meaning set forth in Section 4 of the Indian Health Care Improvement Act and codified in 42 USC § 1603.

"Tribe(s)" means one or more of 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 provided for in OAR 410-120-0000.

"Type B AAA" has the meaning provided for in OAR 410-120-0000.

"Type B Hospital" has the meaning provided for in OAR 410-120-0000.

"Urban" has the meaning provided for 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 provided for in OAR 410-120-0000.

"Usual Charge" and **"UC"** each has the meaning provided for in OAR 410-120-0000.

"Utilization Management Handbook" and **"UM Handbook"** each means the handbook that sets forth all of Contractor's internal policies and procedures relating to the control of the utilization of Medicaid services as described in Ex. B, Part 2, Section 2, Paragraphs c-e.

"Utilization Review" and **"UR"** each has the meaning provided for in OAR 410-120-0000.

"Valid Claim" means a claim received by Contractor for Payment of Covered and Non-Covered Services rendered to a Member which:

(i) Can be processed without obtaining additional information from the Provider of the service; and
(ii) Has been received within the time limitations prescribed in OAR 410-141-141-3565. A "Valid Claim" does not include a claim from a Provider who is under investigation for Fraud or Abuse, or a claim under review for being Medically Appropriate. A "Valid Claim" is a "clean claim" as defined in 42 CFR 447.45(b).

"Valid Encounter Data" means Encounter Data that complies and is submitted in accordance with OAR 410-141-3570.

"Value Based Payment" and **"VBP"** 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:

(i) Foundational Payments for Infrastructure and Operations,
(ii) Pay for Reporting,
(iii) Rewards for Performance/Penalties for Performance,
(iv) Shared savings,
(v) Shared risk,
(vi) Partial Capitation or Episode-based Payments,
(vii) Comprehensive Population-based Payment, and
(viii) Integrated Finance and Delivery System.

"Warm Handoff" has the meaning provided for under OAR 309-032-0860.

"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 410-141-3585.

"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.

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

"Work" means the required activities, obligations, tasks, deliverables, reporting, and invoicing requirements, as described in this Contract.

"Wraparound Care Coordination" means the act of developing and organizing Child and Family Teams to identify strengths and to assess and meet the needs of Members ages 0-17 (or Members who continue receiving Wraparound services from 18-25 years of age) with complex Behavioral Health problems and their families. Wraparound Care Coordination involves: Coordinating services such as access to Assessments and treatment services; Coordinating services across the multitude of systems with which the Member is involved; and Coordinating care with Child Welfare, the juvenile justice system, and/or developmental disabilities system to meet placement needs.

"Wraparound Review Committee" means a group of people from the local Communities representing Child Welfare, Juvenile Justice, Intellectual and Developmental Disabilities, Education, Mental Health, Federally Recognized Tribes or tribal entities, Youth and Family members or youth and family advocates (or both Youth and Family Members and youth and family advocates) who convene with the goal of reviewing and determining Wraparound eligibility. All representatives from all systems participating in a Wraparound Review Committee shall maintain federal level confidentiality standards.

"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.

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

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

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

1. Governing Board and Governance Structure

a. Contractor shall establish and maintain, and operate its organization at the direction of, a Governance Structure that complies with the requirements of ORS 414.572(2)(o) and OAR 410-141-3715.

b. Contractor shall annually provide OHA with either a (i) then-current organizational chart or (ii) a list that presents the identities of, and interrelationships between, the parent entity or organization, Contractor, Affiliated insurers, Affiliated reporting entities, and other Affiliates. The organizational chart or list must show all lines of ownership or Control up to Contractor's ultimate Controlling Person, all subsidiaries of Contractor, and all Affiliates of Contractor that are relevant to the Application that Contractor submitted in response to RFA OHA-4690-19.

(1) In the event there are interrelationships of 50/50% ownership, footnote any voting rights preferences that one of the Persons may have.

(2) For each entity or organization, 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 under this 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 OHA with a description of Contractor's Governing Board's key committees, including each committee's composition, reporting relationships and responsibilities, oversight responsibility, Monitoring activities, and other activities performed.

d. Contractor shall submit its then-current organizational chart or list as required under Para b. above of this Section and its Governing Board and its key committee descriptions as required under Para. c above of this Section 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 must include representation from Behavioral Health, physical health systems, and Oral Health.

3. Tribal Liaison

a. ORS 414.581 established a Tribal Advisory Council. The Tribal Advisory Council is responsible for, among other matters, serving as a channel of communication between Contractor, other CCOs, and Indian Tribes in Oregon regarding the health of Tribal communities. In order to facilitate communication between the Tribal communities and Contractor, the Tribal Advisory Council or particular members of the TAC will work with Contractor to select a Tribal Liaison.

b. The Tribal Liaison shall be an employee or a Subcontractor of Contractor. Contractor's Tribal Liaison shall have the following responsibilities:

(1) Actively participate in the development of the Community Health Assessment as set forth in Exhibit K of this Contract;

(2) Actively participate in the development and drafting of the Community Health Improvement Plan as set forth in Ex. K of this Contract:

(3) Facilitate the resolution of any issues that arise between Contractor and a Provider of Indian health services within Contractor's Service Area;

(4) Serve as the primary point of contact for communicating regularly with the Tribal Advisory Council about matters affecting both Contractor and the Tribal communities within the State; and

(5) Assist with Contractor's training and education programs relating to its services and other matters relating to the specific concerns of Oregon's Tribal communities and the coordinated care health care system.

c. OHA will provide Guidance Documents and technical assistance to assist Contractor and the Tribal Liaison with meeting their respective responsibilities. The Guidance Documents will include, without limitation, a sample job description for the Tribal Liaison which will include the minimum responsibilities, in addition to those set forth above in Para. a of this Sec. 3, Ex. B, Part 1 of this Contract, of such employee or Subcontractor.

4. Innovator Agent and Learning Collaborative

a. OHA will assign an Innovator Agent to Contractor. The Innovator Agent is responsible for: (i) serving as a single point of contact between Contractor and OHA on matters regarding innovation, (ii) facilitating the exchange of information, (iii) working with Contractor and its CAC, and (iv) working with 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 once per month.

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

1. Covered Services

Contractor shall provide and pay for Covered Services as required in this Ex. B, 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, as provided for in OAR 410-141-3830 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 to any Member, Potential Member, or Participating Member, as may be requested from time to time, the criteria for Medically Appropriate determinations with respect to the Benefit Package for physical health, Behavioral Health (which includes mental health and Substance Use Disorders), and Oral.

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 as provided in OAR 410-141-3830.

e. Except as otherwise provided in OAR 410-141-3820, Contractor is not responsible for excluded or limited services as set forth in OAR 410-141-3825.

f. Before denying any Member treatment for a condition that is below the funding line on the Prioritized List of Health Services, including without limitation, disabilities or co-morbid conditions, Contractor shall determine whether the Member has a funded condition/treatment pair that would entitle the Member to treatment under OAR 410-141-3820.

g. Prior to performing any transplant surgery, Contractor shall provide OHA's Provider Clinical Support Unit with Administrative Notice to HSD.Transplants@dhsoha.state.or.us of all transplant Prior Authorizations. Contractor shall use the same limits and criteria for transplants as those established in the Transplant Services Rules in 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.

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

2. Provision of Covered Services

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

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

achieve, as reasonably expected, the purpose for which the services are furnished, which includes 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 create a written Utilization Management Handbook that sets forth Contractor's utilization management policies, procedures, and criteria for Covered Services. The UM Handbook must comply with the utilization control requirements set forth in 42 CFR Part 456, 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 as 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 or 45 CFR § 456.80 for Hospitals);

(5) Initial and subsequent continued stay review dates (described under 42 CFR § 456.233 and § 456.234 for mental Hospitals and 42 CFR § 456.128 and § 456.133 for Hospitals);

(6) Reasons and plan for continued stay if the attending physician determines continued stay is necessary;

(7) Other supporting material the Hospital's utilization review committee believes appropriate to include; and

(8) For non-mental Hospitals only:

(a) Date of operating room reservation; and

(b) Justification of emergency admission, if applicable.

d. Contractor's utilization management policies, procedures, and criteria shall not be structured so as to provide incentives for its Provider Network, employees, or other Utilization Reviewers to inappropriately deny, delay, 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 are no more restrictive than those applied to Fee-for-Service Covered Services, as required under 42 CFR § 438.210(a)(5)(i).

f. Contractor shall provide OHA with its UM Handbook for review and approval 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 review Contractor's UM Handbook for compliance with this Section 2, Ex. B, Part 2 and any other applicable provisions of this Contract. OHA will notify Contractor within thirty (30) days from submission of the approval status of its UM Handbook; OHA will notify Contractor within the same period if additional time is needed for review. 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. Contractor shall also implement a Drug Utilization Review Program as required under 42 CFR § 438.3(s)(4)-(5), 42 CFR Part 456, Subpart K, and Section 1902(oo) of the Social Security Act.

(1) Contractor's DUR Program must meet the following minimum standards as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), 42 USC 1396a(oo). Contractor shall:

(a) Have prospective safety edits on subsequent fills of opioid prescriptions, as specified by OHA, which may include edits to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness;

(b) Have prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions;

(c) Conduct retrospective reviews on opioid prescriptions exceeding above limitations on an ongoing basis;

(d) Conduct retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing basis; and

(e) Have an established process that identifies potential fraud or abuse of controlled substances by Members, health care providers, and pharmacies.

(2) The SUPPORT Act requirement relating to review of antipsychotic agents for appropriateness for children 18 and under applies to OHA, not Contractor, due the carve-out of these agents from the CCO Contract under OAR 410-141-3855.

(3) In connection with such Program, Contractor shall have written policies and procedures that comply with Section 1927 of the Social Security Act and 42 CFR, Part 456, Subpart K and, without limiting the foregoing, must address coverage criteria, which must be developed in accordance with Evidence-Based practices based upon peer-reviewed, clinical literature, and Evidence-Based practice guidelines from national or international professional organizations, or both.

(a) Contractor shall provide its DUR Program policies and procedures to OHA upon request. OHA will notify Contractor within thirty (30) days from submission of the approval status of its DUR Program policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review.

(b) In the event OHA determines that Contractor's DUR Program policies and procedures do not comply with the terms and conditions of this Contract, Contractor shall, in order to remedy the deficiencies in such policies and procedures, follow the process set forth in Ex. D, Sec. 5 of this Contract.

(4) It is Contractor's responsibility to ensure its DUR Program complies with all Applicable Laws and meets the minimum standards listed above for Medicaid managed care entities as required by Section 1902(oo) of the Social Security Act. If requested, Contractor shall provide OHA with an attestation confirming that Contractor's DUR Program complies with all Applicable Laws and this Contract.

3. Authorization or Denial of Covered Services

a. Contractor shall draft a Service Authorization Handbook that sets forth Contractor's written policies and procedures that comply with 42 CFR § 438.210 and OAR 410-141-3835 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 initial and continuing Service Authorization Requests. Such policies and procedures must include, 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, behavioral, or Oral Health condition or disease, as applicable. Contractor shall require its Participating Providers and Subcontractors to adhere to the policies and procedures set forth in the Service Authorization Handbook.

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) Contractor shall implement mechanisms to ensure consistent application of review criteria for Service Authorization and Prior Authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate;

(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, as applicable;

(3) Contractor can require Members and Subcontractors to obtain Prior Authorization for Covered Services from Contractor provided that such Prior Authorization: (i) does not violate any Applicable Law, and (ii) is in accordance with 42 CFR § 438.210(4) and 42 CFR § 441.20 as follows: (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) without limiting a Member's rights under Para. b, Sec. 6 of this Ex, B, Part 2 of the Contract, family planning services are provided in a manner that protects and enables a Member's freedom to choose a method of family planning, and (c) the services furnished are sufficient in amount, duration, and scope as necessary to achieve, as reasonably expected, 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 obtain Medication-Assisted Treatment for Substance Use Disorders, including opioid and opiate use disorders, without Prior Authorization of payment during the first thirty (30) days of treatment. In the event a Member is unable to receive timely access to care as required under this Contract, such affected Member shall have the right to receive the same treatment as set forth herein from a Non-Participating Provider outside of or within Contractor's Service Area. The rights of Members under this Sub. Para.(5), Para. b, Sec. 2 of this Ex. B, Part 2 shall apply to each episode of care;

(6) Members shall have the right to obtain Outpatient Behavioral Health Services or Behavioral Health Peer Delivered Services, without Prior Authorization, except that Contractor shall require Prior Authorization for applied behavior analysis (ABA), electroconvulsive therapy (ECT), Intensive In-Home Behavioral Health Treatment (IIBHT), neuropsychological evaluations, and transcranial magnetic stimulation (TMS).

(7) 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;

(8) Members shall have the right to have a sexual abuse exam without Prior Authorization;

(9) Pursuant to 42 CFR § 438.14(b)(4) and (6), Contractor shall permit (i) its Indian Members to obtain Covered Services from Non-Participating IHCPs from whom the Indian Members are otherwise eligible to receive services; and (ii) Non-Participating IHCPs to refer Indian Members to Participating Providers for Covered Services;

(10) Contractor shall comply with all applicable payment obligations to IHCPs as set forth in 25 USC § 1621e and 42 CFR § 438.14(b)(2) and (c);

(11) In accordance with 42 CFR § 438.210(d)(1), Contractor shall provide notice to, in response to all standard Service Authorization Requests, the requesting Provider as expeditiously as the Member's health or Behavioral Health condition requires, not to exceed 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 an extension, or if Contractor justifies a need for additional information and can demonstrate that the extension is in the Member's interest. In the event Contractor cannot meet the fourteen (14) day time frame, Contractor may extend its time for decision by an additional fourteen (14) days subject to: (i) providing the affected Member and the Member's Provider with written notice of the reason Contractor requires additional time and how such additional time is in the Member's interest and (ii) informing the Member of the right to file a Grievance in accordance with Ex. I of this Contract if such Member disagrees with such request. Contractor shall issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date that the extension expires. In addition, when Contractor fails to provide notice of a decision regarding a Service Authorization Request within the timeframes specified in this Sub. Para. (8) of this Para. b, Ex. B, Part 2, or if Contractor denies a Service Authorization Request, or decides to authorize a service in an amount, duration, or scope that is less than requested, Contractor shall issue a notice of Adverse Benefit Determination in accordance with Exhibit I of this Contract. Upon request, Contractor shall 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;

(12) 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 but in no event more than seventy-two (72) hours after receipt of the request for service. Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Member requests an extension, or if Contractor justifies a need for additional information and 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, 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;

(13) For all covered Outpatient drug authorization decisions, Contractor shall provide a response as described in section 1927(d)(5)(A) of the Act and 42 USC 1396r–8(d)(5)(A) and OAR 410-141-3835;

(14) Contractor shall not have the right to restrict coverage for any Hospital length of stay following a normal vaginal birth to less than forty-eight (48) hours, or less than ninety-six (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;

(15) Contractor shall ensure that Dental Services that must be performed in an Outpatient Hospital ASC, due to the age, disability, or medical condition of the Member, are coordinated and preauthorized;

(16) Contractor shall not have the right, except as permitted under Para. c below of this Sec. 3, 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 undertaking any of the activities set forth below in this Sub. Para. (15), Para. b, Ex. B, Part 2 of this Contract, on behalf of Members who are patients of such Health Care Professionals:

(a) 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) Providing any and all information a Member needs in order to decide among relevant treatment options;

(c) Advising a Member of the risks, benefits, and consequences of treatment or non-treatment; and

(d) Advising and advocating for a Member's right to participate in decisions regarding the Member's own health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(17) 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

(18) 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 of this Contract.

c. In accordance with 42 CFR § 438.102(a)(2), 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 and such objection is not unlawful discrimination; Contractor shall include in its Service Authorization Handbook its policy for such election and include such policy in its Member Handbook in accordance with 42 CFR § 438.10(g)(2)(ii)(A)-(B) and 42 CFR § 438.102(b)(2), how Members may otherwise obtain

information from OHA about how to access such services when not provided by Contractor due to a moral or religious objection.

(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 Contractor shall provide OHA with Administrative Notice of its written policy as follows:

(a) Annually, no later than January 31;

(b) 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) Any time, upon OHA request.

(2) Within thirty (30) days of receipt of Contractor's policy under Sub. Para (1) of this Para. c, Sec. 3, Ex. B, Part 2 of this Contract, OHA will notify Contractor of the approval status of its policy; OHA will notify Contractor within the same period if additional time is needed for review. 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 Section 5, Ex. D.

(3) Contractor shall furnish 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).

4. Covered Service Component: Crisis, Urgent and Emergency Services

Without limiting Contractor's obligation to provide integrated care and coordination for Covered Services, the following responsibilities are required pursuant to OAR 410-141-3840, 42 CFR § 42.114, and other Applicable Laws, and must be implemented in conjunction with 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 on the basis of lists of diagnoses or symptoms.

(2) Contractor shall provide an after-hours call-in system adequate to triage Urgent Care and Emergency Service calls, consistent with OAR 410-141-3840.

(3) As provided for in OAR 410-141-3840 and 42 CFR § 438.114, Contractor shall not deny, and is required to pay for a claim for Emergency Services, regardless of whether the Provider that furnishes the services has a contract with Contractor.

(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 410-141-3840 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 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 Contractor's network, when Contractor could not be contacted for pre-approval or did not respond to a request for pre-approval within one hour.

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

(10) Contractor shall not refuse to cover Emergency Services based on any failure of an Emergency Department Provider, Hospital, or Fiscal Agent to notify a Member's 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 Contractor instructs the Member to seek Emergency Services. 42 CFR § 438.114.

(12) In accordance with OAR 410-141-3945 and 410-120-0000(91) Contractor shall pay for emergency Ambulance transportation for Members, including Ambulance services dispatched through 911 when a Member's medical condition requires Emergency Services.

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

a. Contractor is responsible for ensuring Members have access to safe, timely, appropriate Non-Emergent Medical Transportation services in accordance with OAR 410-141-3920 through 410-141-3965.

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 that describe the process for receiving Member requests, approving NEMT Services, and scheduling, assigning, and dispatching 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) by January 31 of each Contract Year commencing with Contract Year two (2021); (ii) upon any material change to such policies and procedures; and (iii) within five Business Days of request, as made by OHA from time to time. Changes in Contractor's NEMT policies and procedures shall not be

implemented until approved in writing by OHA. If no changes have been made to Contractor's NEMT policies and procedures since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA via Administrative Notice, an attestation signed by Contractor's Chief Executive Officer (CEO) or Chief Financial Officer (CFO) stating that no changes have been made. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website. OHA will notify Contractor within thirty (30) days from submission of the approval status of its NEMT policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review. 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 set forth in Sec. 5, Ex. D of this Contract.

d. All such policies and procedures must be provided to all Members either in Contractor's Member Handbook or in a stand-alone document, referred to as a "NEMT rider guide", that meets the delivery and content specifications in OAR 410-141-3920 and addresses all of the items set forth under Para. e of this Sec. 5, Ex. B, Part 2.

(1) For Contract Year two (2021), Contractor shall provide to OHA, via Administrative Notice, its NEMT rider guide for review and approval: (i) No later than January 5, 2021; (ii) upon any material change prior to or after initial review and approval by OHA; and (iii) within five (5) Business Days after request by OHA as may be made from time to time.

(2) Commencing with the NEMT rider guide for Contract Year three (2022), Contractor shall provide its NEMT rider guide to OHA for review and approval: (i) Annually, not earlier than October 1 and not later than November 1, with any and all updates, new, or corrected information that will be in effect for the upcoming Contract Year; (ii) upon any material change prior to or after initial review and approval by OHA; and (iii) within five (5) Business Days after request by OHA as may be made from time to time.

(3) Contractor's NEMT rider guide must be approved in writing by OHA prior to use. Contractor shall not implement any changes in its NEMT rider guide unless approved in writing by OHA.

e. Contractor's NEMT policies and procedures must specifically include a description of all of the following:

(1) Member and passenger rights and responsibilities, including the right to file a Grievance related to NEMT Services.

(a) If a Member desires to file a Grievance, Contractor shall direct Members to comply with its Grievance and Appeal System in accordance with Ex. I to this Contract. Grievances related to NEMT Services include, without limitation, (i) denial of services in full or in part, (ii) driver or vehicle safety, (iii) quality of services, (iv) appropriateness of services, and (v) access to services.

(b) If Contractor Subcontracts its NEMT Service obligations to a Subcontractor, neither the Subcontractor nor Contractor shall preclude Members from making complaints or Grievances that have been made previously, or from filing or submitting, the same complaint or Grievance to both the NEMT Subcontractor and Contractor.

(c) Contractor shall have a process for documenting, responding to, and addressing or otherwise resolving all service quality complaints or Grievances, or both, regardless

of whether such complaints or Grievances involve services provided by Contractor itself or a Subcontractor.

(2) Approval of NEMT Services which requires Contractor to:

(a) Verify the Member's eligibility for NEMT services;

(b) Determine the appropriate mode of Transportation for the Member;

(c) Determine the appropriate level of service for the Member;

(d) Approve or deny the request in accordance with OAR 410-141-3835 through 410-141-3915, 410-141-3920, and OAR 410-141-3955; and

(e) Enter the appropriate information into Contractor's system.

(3) Verification of eligibility for NEMT Services by screening and confirming all requests for NEMT Services as follows:

(a) That the person for whom the Transportation is being requested is a Member Enrolled with Contractor;

(b) That the service for which NEMT Service is requested is a Covered Service or Health-Related 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 NEMT Services;

(c) That the Member is eligible for services;

(d) For all FBDE Members, verify eligibility for services with such Members' MA or DSN Plans, or directly with such Members' Medicare Provider; and

(e) That the Transportation is a Covered NEMT Service.

(4) Service modifications such that they address the safety of passengers and drivers in accordance with OAR 410-141-3955, 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) Determining the Appropriate Mode of Transportation such that the needs of Members are met by determining and assessing whether the Member:

(a) Is ambulatory and the Member's current level of mobility and functional independence;

(b) Will be accompanied by an attendant, including those permitted under OAR 410-141-3935 and, if so, whether the Member requires assistance and whether the attendant meets the requirements for an attendant;

(c) Is age twelve (12) or under and will be accompanied by an adult;

(d) Has any special conditions or needs including physical or Behavioral Health disabilities and modify, as may be required, the NEMT Services in accordance with OAR 410-141-3955. Based on approval of previous NEMT Services, Contractor shall display Members' permanent and temporary special needs, appropriate mode of Transportation, and any other information necessary to ensure that appropriate Transportation is approved and provided; and

(e) Requires Secured Transport in accordance with OAR 410-141-3940.

(6) Ensuring timely access for NEMT Services, which must include:

(a) Arranging for NEMT Services to be available in a timely manner to ensure Members arrive at their destination with sufficient time to check in and prepare for an appointment. Timely access to NEMT Services also applies to the timely pick up of Members at the end of their appointments to provide the return trip without excessive delay;

(b) Implementing contingency plans for unexpected peak Transportation demands and back-up plans for instances when a vehicle is excessively late (more than fifteen (15) minutes late) or is otherwise unavailable for service; and

(c) Prior to entering into a Subcontract with an NEMT Provider, conducting a readiness review of NEMT brokerages or other entities providing NEMT Services in line with the Subcontractor readiness review requirements. Contractor shall ensure that NEMT drivers undergo background checks and are subject to the Participating Provider credentialing requirements of OAR 410-141-3510 prior to providing services. Contractor shall ensure that NEMT Services are provided using only those vehicles that meet all of the requirements set forth in OAR 410-141-3925 and are operated by drivers who meet all of the requirements of, and have undergone all of, the required screening, credentialed, background checks required, under OAR 410-141-3925.

(7) How NEMT Services are requested, which must permit Members or their Representatives to make requests for NEMT Services on behalf of Members. For purposes of this Sub. Para (7), Para. e, Sec. 5, Ex. B, Part 2, Representatives include the Member's Community Health Worker, foster parent, adoptive parent, or other Provider delegated with this authority.

(8) How Contractor schedules, assigns, and dispatches trips, which must include:

(a) Providing Covered NEMT Services twenty-four (24) hours a day, three hundred and sixty-five (365) days per year and, in accordance with OAR 410-141-3920, permits Members to schedule same day NEMT Services and also up to 90 days in advance, including multiple NEMT Services at one time for recurring appointments;

(b) Scheduling and assigning the requested Transportation to an appropriate NEMT Provider after approving a NEMT Service to be provided by a NEMT Provider (i.e., not fixed route);

(c) Approving and scheduling, or denying, a request for NEMT Services (including all legs of the trip) within twenty-four (24) hours of receiving the request. This

timeframe shall be reduced as necessary to ensure the Member arrives in time for their appointment; and

(d) 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 drivers' locations, and resolve pick-up and delivery issues.

(9) Accommodating Scheduling Changes, which must include the accommodation of unforeseen schedule changes. Such accommodations must include the timely reassignment of the affected trip to, when necessary, another NEMT Provider. Contractor shall ensure that NEMT drivers do not change the assigned pick-up time without prior, documented permission from Contractor or, when such services are Subcontracted, Contractor's NEMT Subcontractor.

(10) How Members are notified of their Transportation arrangements. Such policy and procedure must require notifying Members of the applicable arrangements, when such information is available, during the phone call requesting the NEMT Service. Otherwise, Contractor shall obtain the Member's preferred method (e.g., phone call, email, fax) and time of contact, and Contractor shall notify Members of the Transportation arrangements as soon as the arrangements are in place and prior to the date of the NEMT Service.

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

(12) Contractor's Adverse Weather Plan, 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 education.

(13) Contingency and Back-Up Plans, which must include descriptions of Contractor's contingency plans for unexpected peak Transportation demands and back-up plans for instances when a vehicle is excessively late (more than fifteen (15) minutes late) or is otherwise unavailable for service. Contractor shall ensure that NEMT Providers arrive on time for scheduled pick-ups. The NEMT Provider may arrive before the scheduled pick-up time, but the Member shall not be required to board the vehicle prior to the scheduled pick-up time.

(14) Pick-up and Delivery policies and procedures, which must include Contractor ensuring that:

(a) Drivers make their presence known to Members and require drivers to wait until at least fifteen (15) minutes after the scheduled pick-up time. If the Member is not present fifteen (15) minutes after the scheduled pick-up time, the driver must notify the dispatcher before departing from the pick-up location;

(b) Drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand, or all of the foregoing as applicable);

(c) 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, Contractor shall ensure that 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 office or facility has opened for business, unless requested by the Member or, as applicable, the Member's guardian, parent, or representative, as permitted under OAR 410-141-3920(5)(b)(A); and

(d) The waiting time for Members for pick-up does not exceed fifteen (15) minutes past the scheduled pick-up time. Scheduled pick-up times shall allow the appropriate amount of travel time to assure the 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. Members may not be picked up from an appointment more than 15 minutes after the office or facility closes for business unless the appointment is not reasonably expected to end within 15 minutes after closing or as requested by the Member or, as applicable, the Member's guardian, parent, or representative, as permitted under OAR 410-141-3920(5)(b)(B).

(15) Responding to 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 using the reporting template, if any, posted on the CCO Contract Forms Website. Such Administrative Notice shall be made as specified below. Notwithstanding the requirements of this Sub. Para. (15), Contractor or the NEMT Provider shall report all cases of suspected or known abuse as required by Sec. 33, Ex. D.

(a) Within two (2) Business Days of Contractor becoming aware of the Incident to the following email address: CCO.MCODeliverableReports@dhsoha.state.or.us.

(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, (iv) a description of the Incident and any injuries sustained as a result of the Incident, and (v) 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) Monitoring and Documentation of services, which requires Contractor to:

(a) Subject to OAR 410-141-3965 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;

(b) Subject to the requirements set forth in OAR 410-141-3965, pay for coordination and provision of NEMT Services provided to Members if the Member is eligible for NEMT. Contractor may also pay, with its Health-Related Services funds, for the coordination and provision of NEMT provided to Members if the Member is eligible for NEMT and the request for NEMT is for a Health-Related Service;

(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 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.

f. NEMT Call Center Operations.

(1) In addition to developing and implementing its written NEMT Services policies and procedures, Contractor shall maintain a NEMT Call Center to handle requests for NEMT Services as well as questions, comments, complaints, Grievances, and inquiries from Members and their Representatives, NEMT Providers, and Providers regarding NEMT Services that comply with the terms and conditions set forth in this Para. f, of Sec. 5, Ex. B, Part 2. The NEMT Call Center may use the same infrastructure as Contractor's Member services line, but Contractor shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.

(2) The NEMT Call Center shall operate at a minimum, Monday through Friday from 9:00 a.m. to 5:00 p.m., but 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 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 shall still make NEMT Services available to its Members twenty-four (24) hours a day, three hundred and sixty-five (365) days a year as set forth under Sub. Para. (8)(a), Para. e, above of this Sec. 5 Ex. B, Part 2.

(3) Contractor 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, Contractor shall provide an after-hours message in, at a minimum, English and Spanish. The message must explain how to access the alternative arrangement, in a manner that does not require the Member to place a second call. The outgoing message must also offer the caller the opportunity to leave a message. If the Member's message is discernible and includes a valid phone number for the Member, Contractor shall respond to the message by no later than the next Business Day, with efforts continuing until the Member is reached. All efforts made to reach a Member who has left a message shall be documented in order to demonstrate compliance with this requirement.

(4) 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. 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) Answer rate – At least eighty-five percent (85%) of all calls are answered by a live voice within thirty (30) seconds;

(b) Abandoned calls – No more than five percent (5%) of calls are abandoned; and

(c) Hold time – Average hold time, including transfers to other Contractor staff, is no more than three (3) minutes.

(5) If an NEMT call cannot be answered by a live voice within thirty (30) seconds, 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 asks Contractor to return the call and includes a valid phone number for the Member, Contractor shall promptly return the call within three (3) hours and make, as may be necessary to reach the Member or the Member's Representative, three phone calls within that third (3rd) hour. If the Member or the Member's Representative cannot be reached directly after three phone calls, the person returning the call may instead (i) leave a message for the Member or the Member's Representative with the person answering the call or, (ii) if applicable, leave a voicemail message. All efforts made to reach a Member who has left a message shall be documented in order to demonstrate compliance with this requirement.

(6) Contractor shall have qualified multilingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers. 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) 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 queue, a Spanish-speaking Member queue, an NEMT Provider queue, and a 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) 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's eligibility for NEMT Services, the appropriate mode of Transportation, the purpose of the trip, and all other pertinent information relating to the trip. Contractor may develop additional scripts for other types of NEMT calls from Members, healthcare Providers, and NEMT Providers. Any script for use with a Member shall be written at the sixth (6th) grade reading level. For Contract Year two (2021), Contractor shall provide to OHA, via Administrative Notice, its NEMT Call Center script for review and approval no later than January 5, 2021. Commencing with the script for Contract Year three (2022), Contractor shall provide its NEMT Call Center script to OHA, via Administrative Notice, no later than December 15 of the year immediately preceding the Contract Year. Contractor's NEMT Call Center script must be approved in writing by OHA prior to use; Contractor shall not implement any changes in its script unless approved in writing by OHA. Contractor shall advise callers that calls to the NEMT Call Center are Monitored and recorded for quality assurance purposes.

(9) 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 and audit at least one percent (1%) of calls of each NEMT Call Center staff Member on a monthly basis. Contractor shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. Contractor shall use this Monitoring to identify problems or issues, for quality control and for training purposes. Contractor shall document and retain results of this Monitoring and subsequent training.

(10) Contractor's NEMT Call Center system must collect and document data and produce quarterly and ad hoc reports required under both this Contract and OAR 410-141-3965 as set forth in further detail in Para. g below of this Sec. 5, Ex. B, Part 2.

g. NEMT Quality Assurance Program

(1) In order to ensure Contractor's NEMT Services comply with the terms and conditions of this Sec. 5 of Ex. B, Part 2 and any other applicable provisions of the Contract, Contractor shall develop written policies and procedures outlining the activities for ongoing Monitoring, evaluation, and improvement of the quality and appropriateness of NEMT 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 such policies and procedures to OHA within five (5) Business Days of OHA's request. 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 and improving Member satisfaction with NEMT Services must include, without limitation:

i. Processes for accepting NEMT complaints and Grievances from Members and from others acting on Members' behalf, including medical Providers, as set forth in Sub. Para (1), Para. e, 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 paid for are properly approved and actually rendered, including but not limited to, validation checks and an annual analysis matching claims/encounters for services for which Contractor is fully or partially financially responsible based on the Member's CCO plan type and NEMT claims/encounters;

(c) Contractor's procedures for Monitoring and improving the quality of Transportation provided pursuant to this Contract, including Transportation provided by fixed route; and

(d) Contractor's Monitoring plan for NEMT Providers to ensure compliance with OARs 410-141-3920 through 410-141-3965, which shall include, without limitation, policies and procedures for:

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 maintaining 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, 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 410-141-3520.

(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 after hours

ii. Call wait times, including the average wait time,

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.

h. OHA has the right to request, and Contractor shall provide OHA, with all NEMT documentation, information, reports, phone call recordings, Grievances and other 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. Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care

a. Contractor shall provide preventive services, defined as those services promoting physical, oral and Behavioral Health or reducing the risk of disease or illness included under OAR 410-120-1210, 410-123-1220, 410-123-1260, and 410-141-3820.

(1) Preventative services include, but are not limited to, periodic medical examinations and screening tests based on age, gender and other risk factors; screenings, immunizations; and counseling regarding behavioral risk factors Contractor shall provide, to the extent that they are Covered Services, all necessary diagnosis and treatment services that are identified as a result of providing Member preventive service screenings. To the extent 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 nonetheless Case Management Services (whether dental, Behavioral, physical, or other services), Contractor shall: (i) refer all such affected Members to appropriate Participating or Non-Participating 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 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) 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. 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. In the event 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. Sterilizations and Hysterectomies

(1) Sterilizations and Hysterectomies are a Covered Service only when they meet the federally mandated criteria in 42 CFR §§ 441.250 through 441.259 and the requirements of OHA established in OAR 410-130-0580.

(2) Member Representatives do not have the right to give consent for sterilizations. All consents must comply with the criteria set forth in OAR 410-130-0580.

(3) Copies of all signed informed consents for sterilization and hysterectomies must be provided to OHA, via Administrative Notice, within thirty (30) days after the date of service.

(4) In the event OHA 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, provide Contractor's Encounter Data Liaison with Administrative Notice of such services and the names of Members who received such Services. Contractor shall then, within thirty (30) days of such Administrative Notice, provide, as set forth in OHA's Administrative Notice, the informed consent forms for all Members identified therein by OHA.

(5) OHA in collaboration with Contractor shall reconcile all hysterectomy or sterilization (or both) services with informed consents with the associated Encounter Data by either:

(a) Confirming the validity of the consent and providing Contractor's Encounter Data Liaison, via Administrative Notice, that no further action is needed;

(b) Advising Contractor's Encounter Data Liaison, via Administrative Notice, that OHA requires Contractor to provide corrected informed consent forms to be provided to OHA as set forth in such Administrative Notice; or

(c) Providing Contractor's Encounter Data Liaison with Administrative Notice that informed consent form(s) are missing or invalid and Contractor shall 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 Data to reflect no payment made for service(s).

(6) In the event Contractor fails to comply with the requirements of this Para. c, Sec. 6, Ex. B, Part 2 but nonetheless receives Payment for such procedures, such Payment will be deemed an Overpayment and subject to reporting and return in accordance with Sec. 11, Para. b, Sub. Paras. (15)-(17) of Ex. B, Part 9 and Sec. 15 of Ex. B, Part 9, or set-off as set forth in Sec. 7, Ex. D of this Contract.

d. Post Hospital Extended Care Coordination

(1) PHEC is a twenty (20) day benefit included within the Global Budget Payment. Contractor shall make the benefit available to non-Medicare Members who meet Medicare criteria for a post-Hospital Skilled Nursing Facility placement.

(2) Contractor shall notify the Member's local DHS ADP office as soon as the Member is admitted to PHEC. Upon receipt of such notice, Contractor and the Member's APD 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 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) 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

(6) Contractor is not responsible for the PHEC benefit unless the Member was enrolled with Contractor at the time of the hospitalization preceding the PHEC facility placement.

7. Covered Service Component: Medication Management

a. Except as otherwise provided in this Contract, prescription drugs are a Covered Service for funded Condition/Treatment Pairs, and Contractor shall pay for prescription drugs. Contractor shall provide covered prescription drugs in accordance with OAR 410-141-3855. Prescription drugs and drug classes covered by Medicare Part D for 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.

b. To ensure FBDE Members receive appropriate medications necessary for treatment of physical or Behavioral Health conditions, Contractor shall coordinate with FBDE Members MA and DSN Plans or Part D Plans to ensure Members are connected to Medicare medication management services.

c. In addition to the requirements of its DUR Program as set forth in Sec. 2, Para. g above of this Ex. B, Part 2, Contractor shall also participate in, coordinate with, and respond to the annual CMS Drug Utilization Review survey for the reporting period of October 1-September 30, where September 30 occurs in the preceding Contract Year. The survey, as may be revised by CMS for each reporting period, is located on the CCO Contracts Forms Website. Contractor shall provide its completed survey to OHA, via Administrative Notice, by no later than June 1 following the reporting period. Contractor shall be required to participate in, coordinate with, and respond to any future CMS Drug Utilization Review survey inquiries that may be conducted from time to time.

d. 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 to prioritize service coordination and the provision of other Behavioral 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.

e. Oregon Prescription Drug Program; Agreements with Pharmacy Benefit Managers; Drug Coverage Criteria.

(1) Contractor may contract with the OPDP to provide PBM services.

(2) In the alternative, Contractor may Subcontract for PBM services provided that its Subcontract with its PBM include, in addition to those requirements set forth in Sec. 11 of Ex. B, Part 4 of this Contract, all of the provisions in this Para. e, Sec. 7, Ex. B, Part 2. Contractor may obtain, prior to submitting its PBM Subcontract for review and approval, technical guidance from OHA to ensure its PBM Subcontract complies with all requirements. Technical guidance may be obtained by contacting OHA's Director of OPDP/Pharmacy Purchasing in the Office of Delivery Systems Innovation. Subject to the foregoing, Contractor shall contractually require, without limitation, its PBM to do all of the following:

(a) Incorporate all Applicable Laws relating to PBM services and transparency;

(b) Pass through one hundred percent (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 Contractor has paid to the PBM;

(c) Pass through all rebates and other utilization-based payments made to the PBM by the manufacturers

(d) Permit Contractor to perform an annual audit to ensure its PBM is compliant with contractual requirements and is market competitive;

(e) Require its PBM to obtain a market check which shall clearly identify the comparator data used as the benchmark for the market check and include an analysis of the PBM's current performance in relation thereto.

i. The market check must be performed annually by a neutral, unaffiliated third-party and be completed and delivered to Contractor by July 1 of each Contract Year (beginning in 2021) and subsequently shared with OHA within seven (7) days of delivery to Contractor, which shall be made via Administrative Notice.

(f) Renegotiate and amend 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. 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 contract to establish whether an adjustment should be considered.

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 execute an amendment to the existing pricing terms and other applicable provisions under the PBM contract within thirty (30) days, to be effective on the later of thirty (30) days post signature or by no later than October 1st of the evaluation year.

(g) Identify all provisions that are deemed to be Trade Secrets, Protected Information, and any other provisions that are exempt from public disclosure under Applicable Law;

(h) Provide Contractor with Reports that detail services at the claim level, including NPI or NAPB data fields (or both NPI and NAPB data fields);

(i) Make an attestation of financial and organizational accountability and its commitment to the principle of transparency;

(j) Provide Contractor and OHA with the right to have access to: (i) financial statements upon request, and (ii) 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

(k) Provide 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.

(3) Prior to entering into any Subcontract with a PBM Contractor shall provide OHA, via Administrative Notice, with a copy of the proposed Subcontract. OHA will review the Subcontract for compliance with this Para. e, Sec. 7, Ex. B, Part 2 as well as Sec. 11 of Ex. B, Part 4 of this Contract and provide Contractor's Contract Administrator with Administrative Notice of its approval or disapproval within thirty (30) days of receipt. In the event OHA disapproves of Contractor's Subcontract, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract

(4) Contractor may enter into a pay for performance model Subcontract. In such event, Contractor shall provide OHA, via Administrative Notice, with a copy of its proposed pay-for-performance Subcontract prior to execution by either Contractor and the PBM. OHA will review Contractor's pay-for-performance Subcontract for compliance with this Sub. Para. (4), para. e, Sec. 7, Ex. B, Part 2 and provide Contractor's Contract Administrator with Administrative Notice of its approval or disapproval of such Subcontract within thirty (30) days of receipt. In the event OHA disapproves Contractor's Subcontract, 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 Subcontract with any PBM prior to receipt of OHA's Administrative Notice of approval.

(a) Contractor's model pay-for-performance Subcontract with its PBM shall include all of the following terms and conditions:

i. Require the PBM to provide Contractor with quarterly pharmacy network performance reports that analyze actual pharmacy network performance versus the PBM's rate guarantee in the pay-for-performance Subcontract. Actual pharmacy network performance shall be based off of the PBM's actual contract rate guarantees with its pharmacies in the PBM's pharmacy network. All of which shall be auditable to the claim level;

ii. All such pay-for-performance Reports shall be supported by claim level detail and include pharmacy identifiers, either NPI or NAPB (or both NPI and NAPB data fields);

iii. Require the PBM, upon request, to provide to Contractor, OHA, or their authorized designees (or all or any combination thereof), all contracts the PBM holds with pharmacies for the purpose of verifying that all such contracts comply with OHA's PBM contracting standards; and

iv. Require the PBM to comply with Sub. Paras. (2)(a), (c)-(k) above of this Para. e, Sec. 7, Ex. B, Part 2 of this Contract.

(b) In the event Contractor, after having received approval from OHA, enters into a pay-for-performance contract with a PBM, Contractor shall be required to provide OHA with Reports and provide additional information or documentation (or both) relating to its administrative costs as follows:

i. Contractor shall submit to OHA a Report detailing its total administrative costs per claim. Such administrative costs shall be calculated by including all payments made to its PBM, including Over-Performance. Claim administrative costs paid to its PBM shall be detailed on a line item basis and all reporting shall be submitted in Microsoft Excel file format. Total administrative costs paid per claim shall not exceed OPDP's contracted administrative costs per claim as determined by OHA. Contractor shall submit such Reports to OHA, via Administrative Notice, on a quarterly basis within thirty (30) days after each calendar quarter. OHA shall review Contractor's quarterly Reports to determine whether its administrative costs meet or exceed OPDP's contracted administrative cost per claim as determined by OHA. OHA shall provide Contractor's Contract Administrator with Administrative Notice of its determination within thirty (30) days of receipt of each quarterly Report.

ii. In the event OHA determines that Contractor's total administrative costs per claim exceed OPDP's contracted administrative cost per claim, Contractor shall promptly negotiate new Subcontract terms with its PBM to comply with SubPara. (2)(b) above of this Para. e, Sec. 7, Ex. B, Part 2 of this Contract. Prior to Contractor and the PBM Subcontractor executing the amended Subcontract, Contractor shall submit the proposed amended Subcontract for review and approval in accordance with SubPara. (4)(a) of this Para. e, Sec. 7, Ex. B, Part 2 of this Contract. Upon receipt of OHA's approval of the proposed amended PBM Subcontract, which shall be made via Administrative Notice to Contractor's Contract Administrator, Contractor and its PBM shall execute the approved Subcontract which shall be effective upon the first day of the first full quarter following receipt of OHA's approval. In the event OHA disapproves of Contractor's amended Subcontract, Contractor shall either terminate the then-current PBM Subcontract and transition to the OPDP or follow the process set forth in Sec. 5, Ex. D of this Contract.

iii. Promptly supply additional information and reporting relating to its PBM pay-for-performance Subcontract as may be requested by OHA from time to time.

iv. In the event Contractor requires an extension of a particular deadline, Contractor shall submit such request via Administrative Notice to OHA.

(5) OHA reserves the right to require Contractor to align, for all or some drug classes, its Preferred Drug List with OHA's approved Fee-For-Service Preferred Drug List, including identical preferred and non-preferred drugs and identical criteria for Prior Authorization. OHA shall provide Contractor's Contractor Administrator with Administrative Notice of any and all such alignment requirements.

(6) On or before January 15 of each Contract Year, and again within five (5) Business Days of any change, Contractor shall provide to OHA, via Administrative Notice, in a format required by OHA, the following:

(a) PDLs for all classes; and

(b) Prior Authorization criteria for, at a minimum, all outpatient drugs, including practitioner administered drugs (PADs). Contractor may, at its discretion, include PA criteria for other drugs, in addition to outpatient drugs.

(7) Contractor shall publicly post its current PDL and Prior Authorization criteria. Such information must, when posted, be made readily accessible by patients, prescribers, dispensing pharmacies, and OHA.

8. Covered Service Components: Other Services

a. Intensive Care Coordination

(1) In addition to providing general Coordinated Care Services, Contractor is responsible for assessing, making available, and providing Intensive Care Coordination services in accordance with the requirements set forth in (i) OAR 410-141-3870, (ii) this Para. a., Sec. 8, Ex. B, Part 2, (iii) Sec. 10, Para. b, Ex. B, Part 4, Exhibit M, and (iv) as may be provided for elsewhere in this Contract. Without limiting the foregoing, Contractor shall:

(a) Without requiring a referral, automatically assess all Members of Prioritized Populations for ICC services. Contractor shall make Trauma Informed, Culturally and Linguistically Appropriate ICC services available to all Members of Prioritized Populations who qualify, as a result of such assessment, for such services.

(b) Provide Trauma Informed, Culturally and Linguistically Appropriate ICC services and Behavioral Health Services to children and adolescent Members according to presenting needs.

(c) Provide Trauma Informed, Culturally and Linguistically Appropriate ICC services to Members receiving Medicaid-Funded Long Term Services and Supports including those receiving services in home or community based settings under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver or those in Long Term Care settings.

(d) Assess all Members not identified in SubParas (a)-(c) above of this SubPara (1), Para. a, Sec. 8, Ex. B, Part 2, for ICC services when referred by any of the referrers listed below and make Trauma Informed, Culturally and Linguistically Appropriate ICC services available to all referred Members who qualify for such services as a result of the screening.

i. The Member themselves,

ii. The Member's Representative,

iii. A Provider, including, without limitation, an HCBS Provider or other LTSS Provider, and

iv. Any personnel serving as a member's Medicaid LTSS case manager.

(e) Assess Members who exhibit inappropriate, disruptive, or threatening behaviors in a Practitioner's office or clinic or other health care setting for ICC services.

(f) Provide ICC services in accordance with this Para. a, Sec. 8, Ex. B, Part 2 to Members who are children and adolescents in the custody of DHS and those children and adolescents otherwise identified in Ex. B, Part 4, and Exhibit M.

(g) Respond to requests for Intensive Care Coordination assessment services with an initial response by the next Business Day following the request.

(h) Periodically inform all Participating Providers of the availability of ICC services, providing training to PCPCHs and other PCPs staff regarding the Intensive Care Coordination assessments and services and other support services available to Members.

(i) Ensure that a Member's DHS Area Agency on Aging/Aging and People with Disabilities Office, Office of Developmental Disability Services or local Developmental Disability services provider, long term care provider(s), or Long Term Services and Supports case manager and provider(s) have a direct method to contact the Member's ICC Care Coordination team.

(j) Ensure that the Member's ICC Care Coordinator's name and telephone number are available to agency staff and Members or Member Representatives when ICC services are provided to the Member.

(k) Ensure that the number of Members who are assigned to each ICC Care Coordinator does not exceed each ICC Care Coordinator's capacity to meet all the ICC needs of such assigned Members.

(2) Contractor shall maintain ICC policies and procedures that comply with OAR 410-141-3870, the criteria set forth in this Sec. 8, as well as the criteria and requirements set forth in Sec. 9, Para. a, Ex. B, Part 4, and Exhibit M of this Contract. Contractor's ICC policies and procedures must also include a narrative that details how such policies and procedures will enable Contractor to meet the needs, in complexity, scope, and intensity, of all Members, who qualify for ICC services. Contractor shall submit its ICC policies and procedures to OHA, via Administrative Notice, for review and approval as follows: (i) by January 31 of each Contract Year; (ii) upon any material change to such policies and procedures; and (iii) within five Business Days of request, as made by OHA from time to time. Contractor shall not implement changes in its ICC policies and procedures until approved in writing by OHA. If no changes have been made to Contractor's ICC policies and procedures since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA via Administrative Notice, an attestation signed by Contractor's CEO or CFO stating that no changes have been made. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website. OHA will notify Contractor within thirty (30) days from submission of the approval status of its ICC policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review. In the event OHA determines Contractor's ICC policies and procedures do not comply with the criteria set forth herein, Contractor shall follow the process set forth in Sec. 5 of Ex. D.

(3) Upon request, OHA will provide guidance and technical assistance to assist Contractor in identifying Members of Prioritized Populations and with meeting its ICC responsibilities in accordance with this Contract.

b. Tobacco Cessation

Contractor shall provide Culturally and Linguistically Appropriate tobacco dependence Assessments 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/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 Community Standards, the national standard, or as set forth under OAR 410-130-0190.

c. 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 Para. c, of this Sec. 8, Ex. B, Part 2, "primary treating health professional" means a Health Care Professional responsible for the treatment of the breast or cervical cancer. OHA 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. Oral Health Services

(1) Contractor shall provide to Members all 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 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 410-141-3515. The policies and procedures must describe when treatment of an Emergency Dental Condition or Urgent Care Service should be provided in an ambulatory dental office setting, and when Emergency Dental Services should be provided in a Hospital setting.

(a) For routine 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 treatment or treatment of incipient decay does not constitute emergency care.

(b) Subject to OAR 410-141-3515, for an Emergency Dental Condition, the Member must be seen or treated within 24 hours, and for an Urgent Dental Service within 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. 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 this Contract. Such services not covered include, but are not limited to, the following:

(1) Out-of-Hospital birth (OOHB) services including prenatal and postpartum care for women meeting criteria defined in OAR 410-130-0240. Specifically, OHA will be responsible for providing and paying for Care Coordination related to maternity care and primary OOHB services for those Members approved for OOHBs as well as for those Members in

preliminary approved status. OHA will also be responsible for, with the assistance of Contractor, providing Care Coordination for the services ancillary to OOHBs including, but not limited to, pharmacy, ultrasounds, labs, prenatal vitamins, and all other Covered Services related to typical maternity care. However, Contractor shall be responsible for payment of the foregoing typical ancillary maternity care services and continue to be responsible for providing Care Coordination and payment of Covered Services other than those related to maternity care. OHA shall provide Contractor with a list of Members approved and not approved for OOHB services on a regular basis; and

(2) Long Term Services and Supports excluded from Contractor reimbursement pursuant to ORS 414.631.

b. Contractor shall assist its Members in gaining access to certain Behavioral Health services that are Carve-Out Services, including but 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 reimbursed under 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 Oregon Youth Authority;

(5) Investigation of Members for Civil Commitment;

(6) Long Term Psychiatric Care for Members 18 years of age and older;

(7) Preadmission screening and resident review for Members seeking admission to a LTPC;

(8) LTPC for Members age 17 and under, including:

(a) Secure Children's Inpatient program,

(b) Secure Adolescent Inpatient Program, and

(c) Stabilization and transition services;

(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 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. Non-Covered Health Services without Care Coordination

Non-Covered Services for which Contractor is not required to provide Care Coordination include, but are not limited, to:

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

b. Hospice services for Members who reside in a Skilled Nursing Facility;

c. School-Based Health Services that are Covered Services provided in accordance with Individuals with Disabilities Education Act requirements that are reimbursed with the educational services program;

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

e. Services provided to Citizen/Alien Waived Emergency Medical recipients or CAWEM Plus-CHIP Prenatal Coverage for CAWEM.

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

1. Member and Member Representative Engagement 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 process to help determine the most Culturally and Linguistically Appropriate and effective methods for patient activation, with the goal of ensuring that Members are partners in maintaining and improving their health;

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

c. Educates its Provider Network about the availability, scope of practice, and the benefits of Traditional Health Worker 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. Educates Members on how to navigate the coordinated and integrated health system developed by Contractor by means that may include THWs as part of the Member's primary care team;

e. Encourages Members to make healthy lifestyle choices and to use wellness and prevention resources, including Behavioral Health and addictions treatment, culturally-specific resources provided by Community-Based organizations and service 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. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy to inform Members of rights and responsibilities; and

h. Meaningfully engages the Community Advisory Council to Monitor patient engagement and activation.

2. Member Rights and Responsibilities under Medicaid

Contractor shall have written policies regarding the Member rights and responsibilities under Medicaid law specified below and in OAR 410-141-3590, and Contractor shall:

a. Ensure Members are aware that a second opinion is available from a Health Care Professional within the Provider Network, or that Contractor will arrange for Members to obtain a 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 Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights.

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 OHA Certified or 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, Potential Members, and Provider Network that oral and sign language interpretation 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 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 410-141-3580 and 410-141-3585.

g. Allow each Member to choose the Member's own Health Care Professional from available Participating Providers and facilities to the extent possible and appropriate. For a Member in a Service Area serviced by only one Prepaid Health Plan, any limitation Contractor imposes on Member's freedom to change between Primary Care Providers or to obtain services from Non-Participating Providers if the service or type of Provider is not available with Contractor's Provider Network may be no more restrictive than the limitation on Disenrollment under Sec. 9, below of this Exhibit B, Part 3.

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, including provision of auxiliary aids and services to ensure disability access to health information as required by Section 1557 of the PPACA.

i. Allow each Member the right to: (i) be actively involved in the development of Treatment Plans if Covered Services are to be provided, (ii) participate in decisions regarding such Member's own health care, including the right to refuse treatment; (iii) 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 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 Contractor receives notice of the Member's Enrollment from OHA 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 Plan 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 the Member's dignity and privacy, and the same as non-Members or other patients who receive services equivalent to Covered Services.

o. Ensure, and cause its Participating Providers to ensure, that each Member is free to exercise their Member rights, and that the exercise of those rights does not adversely affect the way 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. 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 the applicable Oregon Administrative Rules.

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

r. If available, and upon request by Members, utilize electronic methods to communicate with and provide Member information.

s. Contractor may use electronic communications for purposes described in 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, hard copy format upon request;

(3) The information does not constitute a direct notice related to an Adverse Benefit Determination or any portion of the Grievance, Appeal, Contested Case 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 for 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 Services plan. Contractor shall develop draft, and provide written informational materials and educational programs consistent with the requirements of OAR 410-141-3580, 410-141-3585, and 42 CFR § 438.10 providing general information to Members and Potential Members about:

(1) Basic features of managed care;

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

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

(4) The Services Area covered by Contractor;

(5) Covered Services and benefits;

(6) The Provider directory;

(7) The requirement for Contractor to provide adequate access to Covered Services.

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 DSN 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.

c. 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

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

(1) Without limiting any other requirements under this Para. d, Sec. 4 of this Ex. B, Part 3, meet the requirements set forth in the Member Communications Requirements document located on the CCO Contract Forms Website.

(a) For each item listed in the Member Communication Requirements document, the column labeled "Text Provided by OHA or Contractor" describes whether OHA or Contractor is responsible for developing the text. OHA will provide OHA text which may be modified and completed as needed for accuracy, and Contractor shall develop the text for items identified on the tool as "Text Provided by Contractor."

(2) Be in English and translated into all other prevalent non-English languages that align with Contractor's particular Service Area;

(3) Include language clarifying or otherwise advise Members that auxiliary aids and other interpretation services are available to deaf or blind Members, Members who are both deaf

and blind available, or Members with other disabilities that require any such service(s) pursuant to Section 1557 of the PPACA or the Americans with Disabilities Act (ADA);

(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) 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) 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 shall 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.

e. Contractor shall develop and provide written informational materials, handbooks and other educational programs as described in OAR 410-141-3580 and OAR 410-141-3585. Such educational programs shall include, without limitation:

(1) A program that addresses Prevention and Early Intervention of illness and disease; and

(2) 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)).

f. Contractor shall submit all Member notices, informational, educational materials, and Marketing Materials to OHA via SharePoint for review and approval by OHA's Quality Assurance (QA) unit: (i) prior to use and distribution to Members or any other third-parties, unless an exception is granted by OHA in writing, 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.

(1) OHA's QA unit will 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.

(2) Contractor shall refer to the Guidance Document located on the CCO Contract Forms Website for guidance as to which materials do and do not require approval from OHA.

(3) In the event OHA implements a system or method other than SharePoint for the submission of Materials for Members and Potential Members for OHA review and approval, OHA shall notify Contractor, via Administrative Notice, at least ninety (90) days prior to the date that Contractor will be required to use the replacement system or method.

g. Contractor shall provide, within five (5) Business Days after the request of a Member, additional information that Contractor has created that has been pre-approved by OHA and is otherwise available, including information on Contractor's structure and operations, and Physician Incentive Plans.

h. Contractor shall 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 QA unit via SharePoint for review and approval. Review and approval or disapproval shall be made in accordance with Para. f 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 QA unit.

i. Contractor shall provide written notice to affected Members of any material change in the information described in this 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. 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 Contractor sufficient notification to meet the thirty (30) day notice requirement. 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 QA unit.

5. Informational Materials for Members and Potential Members: Member Handbook

a. Contractor shall draft and provide each of its Members, and, if applicable, Potential Members with a Member Handbook that contains all of the information specified in Member Communication Requirements, located on the CCO Contract Forms Website.

(1) The information included in the Member Handbook must be consistent with 42 CFR § 438.10(g) and OAR 410-141-3580 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 Health Care Interpreters for spoken and sign language, including written interpreting services and auxiliary aids and services, and also advise them that such services are provided without charge to Members.

b. Contractor shall provide its Member Handbook to OHA for review and approval: (i) Annually, not earlier than October 1 and not later than November 1, with any and all updates, new, or corrected information as needed to reflect Contractor's internal changes and any regulatory changes that will

be in effect for the upcoming Contract Year; (ii) upon any material change prior to or after initial review and approval by OHA; and (iii) within five (5) Business Days after request by OHA as may be made from time to time. Member Handbooks shall be provided to OHA's Quality Assurance unit via SharePoint.

(1) Compliance with the Member Communication Requirements document does not replace Contractor's obligation to satisfy all the requirements of OAR 410-141-3585 and OAR 41-141-3580 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 provisions of this Contract, Contractor shall, in order to remedy the deficiencies in Contractor's Member Handbook, follow the process set forth in Sec. 5, Ex. D of this Contract.

c. Contractor shall both mail and otherwise make its OHA approved Member Handbooks available to Members 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 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) 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) Contractor shall notify all of its Members of each OHA approved revised Member Handbook and its location on Contractor's website. Contractor shall, at the time of such notification, offer to send its Members a printed copy of the applicable revised Member Handbook and promptly do so after such Members so request. Contractor shall provide the same notification to all of its Potential Members and also provide a printed copy to all Potential Members who make such a request.

d. Contractor shall 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 shall develop a Provider Directory for its Members which encompasses the services delivered under this Contract. The Provider Directory shall include with all of the information necessary to ensure Member access to an adequate Provider Network. Contractor may also 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 develop and maintain its Provider Directory such that it meets the requirements set forth in Sec. 4 above of this Ex. B, Part 3, OAR 410-141-3585, 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. 6, 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;

(2) Hospitals;

(3) Pharmacies;

(4) Behavioral Health Providers;

(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 shall also include the following information:

(1) Name and any group affiliation;

(2) Provider Specialty, as appropriate;

(3) Non-English language spoken and information on cultural and the linguistic capabilities (including Sign Language) offered by the Provider or an OHA approved Qualified and, as applicable, Certified Health Care Interpreter(s) at the Providers office;

(4) How to request free oral and written language interpreting services (including Certified and Qualified Health Care Interpreters, and a sign language interpreter) from a particular Provider;

(5) Telephone number;

(6) Street address;

(7) Whether Provider is accepting new CCO Members and how to find out such information;

(8) Website address, 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 written, hard-copy Provider Directory must be updated at least monthly. Contractor's electronic Provider Directory as posted on its website must be updated no later than 30 days after

any change in Providers. In the event Contractor makes any material changes to its Provider Directory, Contractor shall submit such directory to OHA for review and approval in accordance with Paras. f. and h. 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.

j. Contractor shall make its Provider Directory available on its website in a machine readable file and format per 42 CFR § 438.10(h)(4). Contractor shall provide all of its Members with written notice of the availability of the Provider Directory on both its website and, upon request, in written hard-copy. Such letter shall comply with all of the criteria for Member materials as set forth in Sec. 4 above of this Ex. B, Part 3 and submitted, prior to being mailed, to OHA, via Administrative Notice, for review and approval in accordance with the criteria set forth herein. In the event Contractor's letter is not approved, Contractor shall follow the process set forth in Sec. 5 of Exhibit D of this Contract.

7. Grievance and Appeal System

a. Contractor shall create and implement a written a Grievance and Appeal System as set forth with specificity in Exhibit I of this Contract and include such documentation, which must comply with the requirements set forth in Sec. 4 above of this Ex. B, Part 3 and any other applicable requirements set forth in this Contract, in its Member and Provider Handbooks.

8. Enrollment

a. An individual becomes a Member for purposes of this Contract in accordance with OAR 410-141-3805 as of the date of Enrollment with Contractor. As of the date of Enrollment, Contractor shall provide all Covered Services to such Member as required by the terms of this Contract.

(1) For individuals who are Enrolled on the same day as they are admitted to the Hospital or, for children and adolescents admitted to Psychiatric Residential Treatment Services, Contractor is responsible for said services.

(2) If the individual is Enrolled after the first day of a Hospital stay or PRTS, the individual will be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from Hospital services or the PRTS.

(3) For individuals who are Enrolled on the same day as they are admitted to residential treatment services, Contractor is responsible for said services.

(4) If the individual is Enrolled after the first day of admission to residential treatment services, the individual will be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from residential treatment services.

b. The provisions of this Sec. 8, Ex. B, Part 3 apply to all Enrollment arrangements as specified in OAR 410-141-3805. 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 with Contractor by OHA, unless Contractor's Enrollment is closed as provided for Para. d of this Sec. 8, Ex. B, Part 3.

c. Contractor shall not discriminate against individuals eligible to 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 such foregoing characteristics or circumstances.

d. Enrollment with Contractor may be closed by: (i) OHA upon Administrative Notice to Contractor's Contract Administrator, or (ii) by Contractor upon Administrative Notice to OHA's designated OHA CCO Coordinator, 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 410-141-3805.

e. Enrollment with Contractor may be closed by OHA if Contractor fails to maintain an adequate Provider Network sufficient to ensure timely Member access to services.

f. If OHA Enrolls a Member with Contractor in error, OHA will apply the Disenrollment rules in OAR 410-141-3810 and may retroactively Disenroll the Member from Contractor and enroll the Member with the originally intended CCO up to sixty (60) days from the date of the erroneous Enrollment, and the CCO Payment to Contractor will be adjusted accordingly.

g. Contractor shall provide Enrollment validation as described in Sec 11 below of this Ex. B, Part 3.

h. Contractor shall actively participate with DHS and OHA to support the transition of dual eligible beneficiaries from partial CCO/FFS Enrollment to CCO-A and assist these Members in accessing information about opportunities to align and coordinate Medicare benefits with Contractor's Affiliated or Contracted Medicare Advantage or DSN Plan.

9. Disenrollment

The requirements and limitations governing Disenrollments contained in 42 CFR § 438.56 and OAR 410-141-3810 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 410-141-3810.

a. 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 event, Contractor is responsible for Inpatient Hospital services until discharge or until the Member's PCP determines that care in the Hospital is no longer Medically Appropriate. OHA will assume responsibility for other services not included in the Diagnosis Related Group applicable to the hospitalization.

b. 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

(2) Via on-line portal at https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx.

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

(1) If requested orally or in writing by the Member or the Member Representative, OHA may Disenroll the Member in accordance with OAR 410-141-3810 for the following reasons:

(a) Without cause:

i. 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. Newly eligible Members may change plans, if another plan is available, within ninety (90) days of their initial plan Enrollment; or

iii. A Member may request Disenrollment during "OHP eligibility renewal," as such term is defined in OAR 410-141-3805, which is typically twelve (12) months; or

iv. Members who are eligible for both Medicare and Medicaid and Members who are American Indian/Alaska Native beneficiaries may change plans or Disenroll to Fee-for-Service at any time; or

v. Upon Automatic Re-Enrollment (e.g., a Recipient who is automatically re-Enrolled after being Disenrolled, solely because 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. Whenever the Member's eligibility is re-determined by OHA.

(b) With cause:

i. Members may change plans or Disenroll to Fee-for-Service at any time with cause, as defined in 42 CFR Part 438 and Sub. Paras. (ii)-(iv) of this SubPara. (1)(b) of this Para. c, Ex. B, Part 3; or

ii. Contractor does not, because of moral or religious objections, cover the service the Member seeks; or

iii. 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. 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, 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. The Member moves out of the Service Area;

B. Services are not provided in the Member's preferred language;

C. Services are not provided in a culturally appropriate manner;

D. It would be detrimental to the Member's health to continue Enrollment; or

E. For Continuity of Care.

(2) OHA may Disenroll a Member upon request by Contractor if Disenrollment is consistent with routine Disenrollment per OAR 410-141-3810, 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 such Member's OHP Client identification card by a third-party, altering a prescription, theft or other criminal acts committed in or on any Provider's or Contractor's premises.

(3) OHA may Disenroll a Member upon request by Contractor if Disenrollment is consistent with expedited Disenrollment per OAR 410-141-3810, 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 Contractor seriously impairs Contractor's ability to furnish services to either the Member or other Members.

d. Contractor may not request Disenrollment of a Member solely for reasons related to:

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

(2) Utilization of health services;

(3) physical, intellectual, developmental or mental disability;

(4) Uncooperative or disruptive behavior resulting from the Member's special needs, disability or any condition that is a result of their disability, unless otherwise 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) Any other reasons that may be specified in OAR 410-141-3810.

e. 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. If OHA Disenrolls a Member retroactively, OHA will recoup any CCO Payments received by Contractor after the effective date of Disenrollment. If the disenrolled Member was otherwise eligible for the OHP at the time of service, any services the Member received during the period of the retroactive Disenrollment may be eligible for Fee-for-Service payment under OHA rules.

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

h. Disenrollment required by adjustments in Service Area or Enrollment is governed by Sec. 14, of Exhibit B, Part 4 of this Contract.

10. Member Benefit Package Changes

The weekly and monthly Enrollment file (as described in Sec. 11 below of this Ex. B, Part 3 of this Contract) will identify Member's current eligibility status. The file does not include any historical data on Member's eligibility status.

11. Enrollment Reconciliation

a. Contractor shall reconcile the OHA 834 monthly Enrollment transaction file provided by OHA to Contractor, via OHA's secure web portal, with Contractor's current Member information in its Health Information System 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. Contractor shall provide a report of Contractor's current Member information to OHA's Enrollment Reconciliation Coordinator using the Enrollment Reconciliation Certification Forms, which are available on the CCO Contract Forms Website. Such report shall be submitted to OHA's Enrollment Reconciliation Coordinator using secure email with the word "SECURE" written all in capitalized letters in the email subject line. Contractor's determination of the OHA 834 monthly Enrollment transaction files shall be reported as follows:

(1) 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 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) 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 provide 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. 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. 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 410-141-3585. 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. Marketing to Potential Members

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

c. Contractor shall ensure that Potential Members are not intentionally misled about their options by Contractor's staff, activities, or materials. Contractor's Marketing Materials shall not:

(1) Contain inaccurate, false, confusing, or misleading information;

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

(3) Include any State or federal trademarks, trade names, service marks, or other designations; nor

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

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

(b) Contractor is endorsed by CMS, the federal or State government, or other similar entity or agency.

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

(1) 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.

e. Contractor shall provide all proposed Marketing Materials to OHA's QA unit via SharePoint for review and approval 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.

f. With regard to Full Benefit Dual Eligible Members:

(1) Pursuant to OAR 410-141-3575, Contractor may streamline communications to FBDE Members to improve coordination of benefits including development of integrated Member materials (e.g., handbooks, provider directories, summary of Medicare-Medicaid benefits), subject to OHA and CMS Medicare Advantage review and approval.

(2) Contractor may conduct outreach to, or communicate with, FBDE Members in order to notify them of opportunities to align MCE-provided benefits with Medicare Advantage or DSN Plans, as described in OAR 410-141-3575 and OAR 410-141-3580.

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Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems

1. Integration and Coordination

Contractor shall develop, implement, and participate in activities supporting a continuum of care that integrates Behavioral Health, Oral Health, and physical health interventions seamlessly and holistically, including New 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 in accordance with OAR 410-141-3865. Upon initial Enrollment with Contractor, a Member's health risk screening must be completed and documented as quickly as the Member's health condition requires but in no event more than (i) ninety (90) days after the effective date of Enrollment or (ii) within thirty (30) days after the effective date of Enrollment when the Member (x) is Referred, (y) is receiving Medicaid-Funded Long Term Services and Supports, or (z) is a member of a Priority Population for ICC as described in OAR 410-141-3870, or (iii) sooner than the time frames required by the foregoing (i) and (ii) if required by the Member's health condition. Contractor shall maintain documentation on the health risk screening process used for compliance. If the health risk screening requires additional information from the Member, Contractor shall document all attempts to reach the 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 Part 160 and 45 CFR Part 164, Subparts A and E, to the extent that they are applicable, and consistent with other Applicable Law.

b. Contractor shall demonstrate participation in activities supporting the continuum of care that integrates health services by means of, without limitation:

(1) Facilitating enhanced communication and coordination between and among:

(a) Contractor and Oral Health care Providers, and Behavioral Health Providers;

(b) Contractor and MA and DSN Plans and Medicare Providers for FBDE Members;

(c) DHS Area Agency on Aging/Aging and People with Disabilities Offices or Office of Developmental Disability Services case managers, and Providers who provide services to Members receiving Long Term Care or Home and Community Based Services and Members with developmental disabilities who receive services through Community developmental disability programs and organizations.

(2) Educating Members about the Coordinated Care approach being used in the Community, including the approach to addressing Behavioral Health care and be provided with any assistance needed regarding how to navigate Contractor's coordinated care system.

(3) Implementing integrated Prevention, Early Intervention, and wellness activities;

(4) Developing and implementing infrastructure and support for sharing information, coordinating care, and Monitoring results;

(5) Using screening tools and treatment standards and guidelines that support integration;

(6) Supporting a shared culture of integration across CCOs and service delivery systems; and

(7) 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 Contractor furnishes its Members with the services the Member receives from any other 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 in its networks. Contractor shall reimburse the OSPHL for communicable disease testing Laboratory Services provided for 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 (which is subject to change from time to time) is posted at: https://www.oregon.gov/OHA/PH/LABORATORYSERVICES/Pages/test.aspx.

2. Access to Care

Contractor shall provide Culturally and Linguistically Appropriate services and supports in locations as geographically close as possible to where Members reside or seek services. Contractor shall also provide a choice of Providers (including physical health, Behavioral Health, Providers treating Substance Use Disorders, and 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, and underserved populations.

a. Contractor shall meet, and require all 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 410-141-3515 and 410-141-3860. 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 410-141-3515, 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 (MAT) must be provided with an assessment and induction no more than seventy-two (72) hours but Contractor shall undertake and document efforts to provide care as soon as possible and consider providing ICC Services as applicable under OAR 410-141-3870. With respect to those requiring MAT, Contractor shall 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 one (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), in accordance with and subject to 42 CFR § 438.208(c) and as may otherwise be required under this Contract, 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 each such Member's ongoing need for such services and supports and does not create a burden to Members who need 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,

(c) Who are transitioning from a Hospital or Skilled Nursing Facility care,

(d) Who are transitioning from institutional or in-patient Behavioral Health care facilities,

(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.

c. For routine Oral Health care Members 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 care according to the timelines outlined in OAR 410-123-1510.

d. Contractor shall ensure that Providers do not discriminate between Members and non-OHP persons with respect 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 410-141-3515.

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

f. Contractor 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 any other disability. Contractor shall develop appropriate Treatment Plans with such Members and their Families or advocates to manage such behavior.

g. Contractor shall implement mechanisms to Assess each Member with Special Health Care 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 services, or care management, or all or any combination thereof. The Assessment mechanisms must use appropriate health care professionals. For those Members with Special Health Care needs and Members receiving Long Term Services and Supports who are determined to need a course of treatment or regular care Monitoring, Contractor shall:

(1) Develop and implement a written Intensive Care Coordination Plan. 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, (iii) revised upon Assessment of function, need, or at the request of the Member. Such revisions must be done at least every 3 months for Members receiving ICC Services and every twelve (12) months for other Members, if approval is required. All ICCPs must be developed in accordance with any applicable OHA quality Assessment and performance improvement and Utilization Review standards;

(2) Assist such Members in gaining direct access to Medically Appropriate care from physical health or Behavioral Health specialists, or both, for treatment of the Member's condition and identified needs including the assistance available through Intensive Care Coordinators if appropriate; and

(3) Contractor shall implement procedures to share with such Member's Primary Care Provider the results of its identification and Assessment so that those activities are not duplicated. Contractor's procedures shall also require that the Members' Assessments be shared with other MCEs serving the Members. Such coordination and sharing of information must be conducted in accordance with Applicable Laws governing confidentiality.

h. Contractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to Members 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 Health Care Interpreter services for those Members who have difficulty communicating due to a medical condition, disability, or limited English proficiency, or where no adult is available to communicate in English, or there is no telephone and providing access to auxiliary aids and services. Contractor shall maintain written policies, procedures, and plans in accordance with the requirements of OAR 410-141-3515.

i. Contractor shall comply with the requirement of Title II of the Americans with Disabilities Act by ensuring that services provided to Members with disabilities are provided in the most integrated setting appropriate to the needs of those Members.

j. 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.

k. In addition to access and Continuity of Care standards specified in the rules cited in Para. a, of this Sec. 2, Ex. B, Part 4, Contractor shall develop a methodology for evaluating access to Covered Services as described in Sec. 1, Ex. G of this Contract and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-33515, OAR 410-141-3860, and OAR 410-141-3865.

(1) Using the Interpreter Services Self-Assessment reporting template located on the CCO Contract Forms Website, Contractor shall conduct an annual language access self-assessment and submit the completed self-assessment to OHA, via Administrative Notice, by the third Monday of each January.

(2) Using the Language Access reporting template located on the CCO Contract Forms Website, Contractor shall collect and report language access and interpreter services to OHA. The Report 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 for the preceding calendar quarter.

l. 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 410-141-3860 and required by 42 CFR 438.208 (b)(1) and (2).

m. Contractor shall, in accordance with 42 CFR § 438.14(3) permit any and all of its AI/AN Members who are eligible to receive services from an IHCP PCP who is a Participating Provider, to choose such IHCP as their PCP so long as such IHCP PCP has the capacity to provide such services.

(1) Any Referral to another Participating Provider from an IHCP PCP who is a Participating Provider shall be deemed to satisfy any of Contractor's coordination of care or Referral obligations.

n. 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.

o. Contractor shall provide for a second opinion from a Participating Provider, which may include, if appropriate, a Participating Behavioral Health Provider to determine Medically Appropriate services. If a 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.

p. To effectively integrate and coordinate health care and care management for FBDE Members, Contractor shall demonstrate its ability to integrate and provide Medicare and Medicaid benefits to FBDE Members through direct affiliation or contract with one or more MA Plans that serve FBDE Members throughout the entirety of Contractor's Service Area. 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 DSN Plan mechanisms for newly eligible Medicare Members.

q. In the event Contractor is unable to provide local access to care by Health Care Professionals or other 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 410-141-3515.

3. Delivery System and Provider Capacity

a. Delivery System Capacity

(1) As specified in 42 CFR § 438.206, Contractor shall maintain and Monitor a Participating Provider Network that is supported with written agreements (as specified in Exhibit D, Section 19 and this Exhibit B, Part 4, Section 12 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 OAR 410-141-3515, ORS 414.609, and other Applicable Law, to Members across the age span from child to older adult, including FBDE Members.

(2) Contractor shall ensure all Members have access to a Provider Network that meets the needs of its Members and Potential Members. Contractor shall contract with an appropriate number of Providers to ensure Member access to a full continuum of Behavioral Health, physical, and Oral Health services throughout Contractor's Service Area. Contractor shall contract with an appropriate number of Providers to anticipate potential access to care issues in the event of a contracted Provider leaving the network. In establishing and maintaining the Provider Network, Contractor shall develop and implement a methodology to establish and Monitor Provider Network capacity based on at a minimum, the following factors:

(a) The anticipated Medicaid Enrollment and anticipated Enrollment of 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 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) There are, in accordance with 42 CFR § 438.14(b)(1), a sufficient number of IHCP Participating Providers to ensure all eligible AI/AN Members receive, from such

IHCPs, timely access to all of the services required to be provided under this Contract.

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

(g) Data collected from Contractor's Grievance and Appeal System;

(h) Data collected from Contractor's Monitoring of Member wait time to appointment;

(i) Any deficiencies in network adequacy or access to services identified through the course of self-audit, reviews conducted by OHA's contracted EQRO, Monitoring conducted by OHA, or audits conducted by any other State or federal agency;

(j) 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 414.609;

(k) The number of Providers who are not accepting New Members; and

(l) The number of Members assigned to PCPCHs.

(3) As set forth in additional detail in Ex. G of this Contract, Contractor shall Report on its Delivery System Network identifying all individual Providers and facilities that hold written agreements with Contractor to provide services to its Members, including an appropriate range of preventive, primary care, Behavioral Health, Oral Health, and other specialty services, sufficient in number, mix and geographic distribution to meet Member needs.

(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 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 those with medication assisted therapy needs.

4. Provider Selection

Contractor shall establish written policies and procedures that comply with credentialing and re-credentialing requirements outlined in OAR 410-141-3510, 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:

(1) Complete and provide OHA with DSN Provider Reports as set forth in Exhibit G to this Contract;

(2) 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 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) 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 410-141-3560;

(5) Ensure that all Traditional Health Workers, whether they are Subcontractors or Contractor employees, undergo and meet the requirements for, and pass the background check required of for THWs, as described in OAR 410-180-0326;

(6) Terminate its contract or Subcontract with a Provider immediately upon receipt of Legal Notice from the State that a Provider is precluded from being enrolled as a Medicaid Provider; and

(7) Apply the same credentialing and Enrollment criteria required of Providers enrolling with OHA as Fee for Service Providers.

b. In accordance with 42 CFR § 438.602(b)(1) OHA will screen and enroll Providers and revalidate all of Contractor's Providers as Medicaid Providers. Contractor may execute provisional Provider contracts pending the outcome of screening and Enrollment with OHA, for no longer than one hundred and twenty (120) days. Contractor shall terminate the contract immediately if notified by OHA that the Provider is precluded from being enrolled as a Medicaid Provider. Notwithstanding the foregoing, Contractor shall not execute provisional Provider contracts with moderate or high-risk Providers who are required to undergo fingerprint-based background checks until the Provider has been approved for Enrollment by OHA.

5. 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 Health, SUD 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 410-141-3510 and Exhibit G of this Contract, except as provided in Para. b below of this Sec. 5, 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 types designated by CMS as "moderate or "high-risk," Contractor shall, 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 five (5) years. For a Provider 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.

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 in the DSN Provider Report required under Ex. G of this Contract, the date such Provider's education, experience, competence, and supervision are adequate to permit 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) Meet the definitions for Qualified Mental Health Associate or Qualified Mental Health Professional and must not be permitted to provide services without the supervision of a Licensed Medical Practitioner; or

(b) If not meeting either the definitions of a QMHP or QMHA, have the education, experience, and competence necessary to perform the specified assigned duties. In such instances Contractor shall 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 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 Contractor shall obtain documentation from the program or facility that demonstrates accreditation by nationally recognized organizations recognized by 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 410-141-3510 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. 4, 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 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 in the 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 Applicable Law. If Contractor knows or has reason to know that a Provider's license or certification is expired, has not been renewed, or is subject to sanction or administrative action, Contractor shall immediately provide OHA with Administrative Notice of such circumstances.

g. Contractor 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 shall not employ or contract with Providers excluded from participation in Federal health care programs under 42 CFR § 438.214(d). Contractor shall not accept claims for services provided to Members 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 laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), Contractor shall immediately provide such information to OHA via Administrative Notice.

h. Contractor shall not pay for 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) under any of the following circumstances:

(1) 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, 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, 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. Contractor shall only use registered National Provider Identifiers (NPIs) and taxonomy codes reported to OHA in its DSN Provider Capacity Report (as required under Ex. G of this Contract) for purposes of Encounter Data submission, prior to submitting Encounter Data in connection with services by the Provider.

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

k. Contractor shall provide training for Contractor staff and Participating Providers and their staff regarding the credentialing of Providers and the delivery of Covered Services, applicable administrative rules, and Contractor's administrative policies as set forth in Sec. 11, para. b, Sub. Para. (8) of Ex. B, Part 9.

6. Patient Centered Primary Care Homes

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 the Provider reporting requirements required under this Contract and Applicable Law, Contractor shall provide OHA with an annual Report with facility-level data about all Members who are assigned to a PCPCH Provider. Such annual Report shall be provided to OHA,

via Administrative Notice, within thirty (30) days after the end of the reporting Contract Year. OHA will provide Contractor with timely special instructions regarding the Administrative Notice submission process required to be used for submitting the annual PCPCH Report. The Report about Members who were assigned to a PCPCH Provider during Contract Year one (2020) shall be due by no later than January 30, 2021, and the Report about Members who were assigned to a PCPCH Provider during Contract Year two (2021), which is the final Report, shall be due by no later than January 30, 2022. Contractor shall coordinate with each PCPCH Provider in developing these lists and the report shall list facility-level data about all such Members by tier levels 1, 2, 3, 4, or 5. In addition to the Reporting obligations under this Para. b, Section 6, Ex. B, Part 4, OHA reserves the right to require Contractor to provide Member-level PCPCH enrollment data as may be specified otherwise in this Contract.

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. Contractor shall contract with a network of PCPCHs recognized under Oregon's standards (OAR 409-055-0000 to 409-055-0090).

f. Contractor shall ensure that Members of all Communities in its Service Area receive Integrated, Culturally and Linguistically Appropriate person-centered care and services, and that Members are fully informed partners in transitioning to and maximizing the benefits of this model of care. In order to ensure Members have the ability to utilize such model of care, Contractor shall:

(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) Negotiate a rate of reimbursement with FQHCs and RHCs that is not less than the level and amount of payment which 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 Section 4712(b)(2) of the Balanced Budget Act of 1997;

(3) Offer contracts to all Medicaid eligible IHCPs in 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 within Contractor's network;

(4) Adopt the CMS "Model Medicaid and Children's Health Insurance Program Managed Care Addendum for Indian Health Care Providers" or an addendum agreed upon in writing by Contractor and every Tribe and IHCP in Contractor's Service Area. IHCPs may agree to include additional provisions in the Model IHCP Addendum. The Model IHCP Addendum is located at: https://www.medicaid.gov/sites/default/files/2019-12/addendum-ihcps.pdf; and

(5) Contractors and IHCPs interested in entering into a contract must reach an agreement on the terms of the contract within six months of expression of interest or initial discussion between Contractor and IHCP, unless an extension is agreed upon by both parties.

(a) If 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 representative to assist with negotiation of the contract.

(b) The State will use an informal process to facilitate an in-person meeting with Contractor and IHCP to assist with the resolution of issues.

(c) If an informal process does not lead to an agreement, Contractor and IHCP will use the existing dispute resolution process described in OAR 410-141-3560. The informal process shall be used as guidance and will not be binding.

(d) Upon agreement of terms Contractor and IHCP must finalize and approve the contract within ninety (90) days of reaching an agreement.

7. Care Coordination

Contractor shall provide all of the elements of Care Coordination as set for the below in this Sec. 7, Ex. B, Part 4.

a. Contractor shall support the appropriate flow of relevant information; identify a lead Provider or primary care team to manage Member care and coordinate all Member services; and, in the absence of full health information technology capabilities, implement a standardized approach to 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 Plans or Medicare Providers, to develop the partnerships necessary to allow for access to, and coordination with, social and support services, including culturally specific Community-based organizations, Community-Based Behavioral Health services, DHS Medicaid-Funded Long Term Services and Supports providers and case managers, including Home and Community Based Services under the State's 1915(i) or 1915(k) State Plan Amendments or the 1915(c) HCBS Waiver, DHS Office of Developmental Disability Services, Community-based developmental disability Providers and organizations, and mental health crisis management services;

c. Contractor shall develop Culturally and Linguistically Appropriate tools for Provider use to assist in the education of Members about roles and responsibilities in communication and Care Coordination;

d. Contractor shall coordinate with DHS Medicaid-Funded Long Term Services and Supports Providers and Type B AAAs or State APD district offices in its Service Area for Members receiving DHS Medicaid-Funded Long Term Services and Supports and shall maintain a partnership with the aforementioned entity(ies) supported by a Memorandum of Understanding (MOU) that incorporates processes including monitoring for care planning, care transitions, and communication, as outlined in the 2020 CCO-LTSS Guidance Document provided by OHA.

(1) Contractor shall submit a new MOU that meets the requirements specified in the 2020 CCO-LTSS Guidance Document to OHA, via Administrative Notice, no later than January 15 of Contract Year two (2021). The Guidance Document is located on the CCO Contract Forms Website. Contractor shall submit annually any updates or revisions to the MOU to OHA, via Administrative Notice, no later than January 31 of each subsequent Contract Year.

(2) MOUs are subject to review and approval by DHS-APD and OHA, 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.

(3) Commencing in Contract Year three (2022), Contractor shall document and submit annually no later than March 15 an MOU report on coordination activities and required

domain metrics for the preceding Contract Year as outlined in the 2020 CCO-LTSS Guidance Document.

e. Contractor shall coordinate with residential 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 Behavioral Health services.

f. Contractor shall coordinate with the Oregon State Hospital, other State institutions, and other Behavioral Health Hospital settings, to facilitate Member transition into the most appropriate, independent, and integrated Community-based settings.

g. Contractor shall use Evidence-Based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness, Special Health Care Needs, or other chronic conditions, who receive home and Community-Based services under Section 1915(i), 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 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 and Linguistically Appropriate fashion and to integrate the use of HIE and event notification.

h. Contractor shall report on its Care Coordination activities as required by OAR 410-141-3860 and submit the report to OHA, via Administrative Notice, according to the schedule specified in the rule.

8. Care Integration

a. Contractor shall provide the elements of integrated care as set forth in this Para. a, Sec. 8, Ex. B, Part 4. Accordingly, Contractor shall:

(1) Integrate Outpatient Behavioral Health Services with a person-centered care delivery system which must be coordinated with physical health care services by Contractor and by Contractor's transformed health system;

(2) Provide adequate and appropriate access to dental Providers for Oral Health services;

(3) Provide adequate, timely and appropriate access to specialty and Hospital services. Contractor's service agreements with specialty and Hospital Providers must: (i) address the coordinating role of patient-centered primary care; (ii) specify processes for requesting Hospital admission or specialty services; and (iii) establish performance expectations for communication and medical records sharing for specialty treatments: (x) 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 is responsible for holding Hospitals and specialty service Providers accountable for achieving successful transitions of care. Contractor's primary care teams are responsible for transitioning Members out of

Hospital settings into the most appropriate, independent, and integrated care settings, including home and Community-Based as well as Hospice and other palliative care settings; and

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

b. Contractor is responsible for documenting, and maintaining such documentation, that Members have been provided with all of the features of the delivery system as set forth below. Accordingly, Contractor shall 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) Had their supportive and therapeutic needs addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible;

(3) Received comprehensive Transitional Care, including appropriate follow-up, when such Member entered and left and Acute care facility or a long term care setting;

(4) Received assistance in navigating the health care delivery system and in accessing Community and social support services and statewide resources;

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

(6) Been 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; and

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

9. Delivery System Dependencies

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

(1) Contractor shall prioritize working with Members who are eligible for ICC Services and communities experiencing health disparities (as identified in the Community Health Assessment). Contractor shall actively engage such Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable Emergency Department 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 ICC Services as set forth in Sec. 8, Para. a., of Ex. B, Part 2 and Sec. 11 of Ex. M 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 (i) having Special Health Care Needs, including older adults, (ii) being blind, deaf, hard of hearing, or have other disabilities, (iii) having complex medical health needs, high health care needs, multiple chronic conditions, Behavioral Health issues, including SUD, or (iii) receiving Medicaid-Funded Long Term Services and Supports including Long-Term Care or 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 414.607 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) 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 or receiving LTSS, including a standing Referral process for direct access to specialists. Contractor shall ensure that each Treatment Plan:

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

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

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

(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 and local government agencies and culturally diverse Community social and support services organizations, including early child education, special education, Behavioral Health and public health, as critical for the development and operation of an effective delivery system. 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, and (ii) assist Providers in referring Members to the appropriate Providers or organizations. Contractor shall ensure that the assistance provided regarding Referrals to State and local governments and Community social and support services organizations takes into account the Referral and service delivery factors identified in the Community Health Assessment and Community Improvement Plan.

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, in an Outpatient Hospital or ASC, when a Member's age, disability, or medical condition necessitates providing services in 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 facilities, and in group or foster homes. All medications

shall be provided in a format that is reasonable for each facility, including the manner of delivery, dosage, and packaging requirements and 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.

10. Evidence-Based Clinical Practice Guidelines

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

11. Subcontract Requirements

Contractor's Subcontracts, including those entered into with Providers, must comply with the requirements set forth in this Sec. 11 of Ex. B, Part 4. However, nothing in this Sec. 11 precludes Contractor from including additional terms and conditions in its Subcontracts provided that such additional terms and conditions do not conflict with or otherwise amend 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, at a minimum, comply with all of the following:

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: (i) are in writing, (ii) specify the Subcontracted Work and reporting responsibilities, (iii) are in compliance with the requirements described below in this Sec. 11, Ex. B, Part 4 and any other requirements identified in this Contract, and (iv) incorporate the applicable provisions of this Contract, based on the scope of Work Subcontracted such that the provisions of the Subcontract are the same as or substantively similar to the applicable provisions of this Contract.

(3) Contractor acknowledges and agrees that it is a "Covered Entity" and that it may, from time to time, enter into Subcontracts with a "Business Associate" as both such terms are defined under 45 CFR § 160.103. Accordingly, Contractor shall ensure it enters into Business Associate agreements with its Subcontractors when required under, and in accordance with, HIPAA.

(4) Contractor shall evaluate and document all prospective Subcontractors' readiness and ability to perform the scope of Work set forth in the applicable Subcontract prior to the effective date of the Subcontract. OHA shall have the right to request, and Contractor shall provide within five (5) days after request by OHA, all readiness review evaluations.

(5) Contractor shall ensure that all Subcontractors are screened for exclusion from participation in federal programs. In the event a Subcontractor is so excluded, Contractor is prohibited from Subcontracting to such Subcontractor any Work or obligations required to be performed under this Contract.

(6) Contractor shall ensure that all Subcontractors and their employees undergo a criminal background check prior to starting any Work identified in this Contract.

(7) Contractor shall not have the right to Subcontract certain obligations and Work required to be performed under in this Contract. Work, activities, and other obligations that Contractor shall not Subcontract are identified throughout this Contract. Subject to the provisions of this Section 11, Ex. B, Part 4, Contractor may Subcontract obligations and Work required to be performed under this Contract that is not expressly identified as an exclusion. 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. A breach of the requirements 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, Recoupment, Withholding, and other recovered amounts and enforcement actions against any Subcontract is solely the responsibility of Contractor. Contractor retains all legal responsibility and shall not have the right to Subcontract the responsibility for Monitoring and oversight of Subcontracted activities.

(8) Contractor shall provide to OHA, via Administrative Notice, a Subcontractor and Delegated Work Report in which Contractor shall summarize in list form all Work and other activities required to be performed under this Contract that have been Subcontracted to a Subcontractor. The Subcontractor and Delegated Work Report must be provided to OHA by no later than January 31 of each Contract Year and within thirty (30) days after there has been any change in a Subcontractor or the Work Delegated to such Subcontractor. The Subcontractor and Delegated Work Report shall also include all of the following:

(a) The legal name of the Subcontractor;

(b) The scope of Work being Subcontracted;

(c) Copies of ownership disclosure form, if applicable;

(d) Any ownership stake between Contractor and the Subcontractor; and

(e) An attestation that Contractor has (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

(9) In addition to the obligations identified as being precluded from Subcontracting under this Sec. 11, Ex. B, Part 4 of this Contract, and as may be set forth in any other provision of this Contract, the following obligations of Contractor under this Contract shall not be Subcontracted or otherwise Delegated to a third party:

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

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

(10) If deficiencies are identified in Subcontractor performance for any functions outlined in this Contract, whether those deficiencies are identified by Contractor, by OHA, or 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.

(11) 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 410-141-3565.

(12) In accordance with Exhibit I of this Contract, Contractor shall provide every Provider and Subcontractor, at the time it enters into a contract or Subcontract, its OHA-approved written procedures for its Grievance and Appeal System.

(13) Contractor shall Monitor the performance of all Subcontractors on an ongoing basis and perform, at least once a year, a formal review of compliance with all Subcontracted obligations and other responsibilities, performance, deficiencies, and areas for improvement. Such review shall be documented in an Annual Subcontractor Performance Report, 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.

(14) The Annual Subcontractor Performance Report must include at a minimum the following elements:

(a) An assessment of the quality of Subcontractor's performance of contracted Work;

(b) Any complaints or Grievances filed in relation to Subcontractor's Work;

(c) Any late submission of reporting deliverables or incomplete data;

(d) Whether employees of the Subcontractor are screened and 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.

(15) Contractor shall provide a copy of each Annual Subcontractor Performance Report to OHA, via Administrative Notice, within thirty (30) days of completion. Contractor shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has Delegated to a Subcontractor.

(16) In the event Contractor identifies deficiencies or areas for improvement, Contractor shall cause Subcontractor to implement a Corrective Action Plan to remedy such deficiencies. In addition, Contractor shall provide to OHA, via Administrative Notice, a copy of the CAP documenting the deficiencies, actions required of the Subcontractor to remedy the deficiencies, and the time frame for completing such required actions. The foregoing Administrative Notice shall be made within fourteen (14) days after providing the Corrective Action Plan to the applicable Subcontractor.

(17) Contractor shall provide OHA with an update on the status of the Corrective Action Plan at such time that the Subcontractor has (i) been successfully removed from Corrective Action or, (ii) of the Subcontractor's failure to fully remedy the underlying deficiency if the deadline for such remedy has passed. Such update shall be provided to OHA, via Administrative Notice, within fourteen (14) days after the intended original completion date set forth in the applicable CAP.

b. Requirements for Written Agreements with Subcontractors

(1) Contractor shall include in all of its Subcontracts with its Subcontractors all of the following:

(a) Provide for termination of the Subcontract, 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 Contractor determine the Subcontractor has breached the terms of the Subcontract;

(c) Require Subcontractor to comply with the payment, withholding, incentive and other requirements set forth in 42 CFR § 438.6 that are applicable to the Work required under the Subcontract;

(d) Require 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 valid, accurate, Encounter Data submission as required under Ex. B, Part 8 and other provisions of this Contract;

(e) An express statement whereby Subcontractor agrees to comply with all Applicable Laws, including, without limitation, all Medicaid laws, rules, regulations, as well as all applicable sub-regulatory guidance and contract provisions;

(f) An express statement whereby Subcontractor agrees that OHA, the Oregon Secretary of State, CMS, 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, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract;

(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 outlined in this 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 for a period of ten (10) years from this Contract's Expiration Date or from the date of completion of any audit, whichever is later;

(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;

(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 shall document and maintain all Monitoring activities;

(m) Require Subcontractors and Participating Providers to meet, the standards for timely access to care and services as set forth in this Contract and OAR 410-141-3515, which includes, without limitation , providing services within a time frame that takes into account the urgency of the need for services 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; and

(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) Contractor shall have thirty (30) days to 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 Entities Report.

(4) Contractor shall 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 or Contractor's Subcontract with its Subcontractor;

(b) For reasons related to Fraud, integrity, or quality;

(c) Deficiencies identified through compliance 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.

e. Within two (2) Business Days after receipt written request, which may be made, via Administrative Notice, to Contractor's Contract Administrator, Contractor shall provide OHA with any and all copies of Subcontracts entered into by Contractor that relate to the services required to be provided under this Contract. Such Subcontracts shall be provided to OHA in the manner directed by OHA in its request.

12. Minority-Owned, Woman-Owned and Emerging Small Business 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 and Woman Business Enterprise. Emerging Small Business 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 to work on the Contract, it is the expectation of OHA that Contractor will take reasonable steps to ensure that MWESB certified firms, as referenced on: https://www.oregon4biz.com/How-We-Can-Help/COBID/.

13. 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 with Contractor, Contractor shall provide to OHA, via Administrative Notice, 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 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 of a substantial number of Members from Contractor, Contractor shall provide OHA, via Administrative Notice, with written

notice of such change and a plan for implementation at least ninety (90) days prior to the date of the implementation of such 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 410-141-3850.

c. OHA will not approve a transfer of Members if the Provider's contract with the transferring CCO is terminated for reasons related to quality of care, competency, Fraud or other reasons described in OAR 410-141-3810.

d. OHA reserves the right to waive or otherwise amend the required time period in 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 shall terminate a Provider or group due to circumstances that could compromise Member care;

(2) If a Provider or group terminates its Subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required ninety (90) day notice; or

(3) At OHA's discretion.

e. OHA will reassign any transferring Members to another Managed Care Entity in the Service Area with sufficient capacity or may seek other avenues to provide services to 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 to all Members for which Contractor received a CCO Payment.

g. If Members are required to Disenroll from Contractor pursuant to this Sec. 13, 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 at 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's new Providers, and to any designated PCP.

h. Contractor shall complete submission and corrections to Encounter Data for services received by Members; shall assure payment of Valid Claims by employees and Subcontractors, and for Non-Participating Providers providing Covered Services to Members; and shall comply with the other terms of this Contract applicable to the dates of service before Disenrollment of Members pursuant to this Sec. 13, Ex. B, Part 4 of this Contract. OHA 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 410-141-3805.

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:

k. 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.

l. 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.

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

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Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations

1. Record Keeping Requirements

a. In accordance ORS 414.572 (2)(m), Contractor shall use best practices in the management of its finances, contracts, claims processing, payment functions and Provider Networks.

b. Contractor shall provide OHA, its 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 such parties in the collection of information for the purposes of Monitoring compliance with this Contract, including but not limited to verification of services actually provided, and for developing, Monitoring, and analyzing performance and outcomes. Collection methods with which Contractor shall 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 established by OHA for evaluating 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 PCPCHs, the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA 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). Notwithstanding any shorter retention period that may be required under 42 CFR §§ 438.5(c), 438.604, 438.606, and 438.608, 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) Provides sufficient detail and clarity to permit internal and external review to validate Encounter Data submissions and to assure Members have been, and are being, provided with Medically Appropriate services consistent with the documented needs of the Member;

(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 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 review all of its internal record keeping policies and procedures on a biennial basis or as required by other sections in this Contract.

g. Contractor shall inform OHA if it has been accredited by a private independent accrediting entity. If 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, and summaries of findings; and

(3) Expiration date of the accreditation.

2. Privacy, Security, and Retention of Records; Breach Notification

a. In accordance with OAR 410-141-3520 Contractor's record keeping system 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. Contractor shall have written policies and procedures regarding the access, use, and transmission of records that comply with ORS 413.171, OAR 943-014-0300 through 943-014-0320, OAR 943-120-0000 through 943-120-0200, and this Sec. 2, of this Ex. B, Part 8. Contractor shall also allow OHA to Monitor compliance with Contractor's Records Security Policies.

b. In accordance with OAR 410-141-3520, Members must have access to 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 Members for reasonable duplication costs when they request copies of their records.

c. Pursuant to ORS 414.607(3) and notwithstanding ORS 179.505, Contractor and its Provider Network, 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, lowering the cost of care, and improving the health and well-being of the Members.

d. Pursuant to ORS 414.607(4) Contractor and its Provider Network 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 all other Applicable Laws relating to health information privacy. Redisclosure of individually identifiable information outside of Contractor's organization and its Provider Network for purposes unrelated to this section or the requirements of ORS 414.572, 414.632, 414.605, 414.638, 414.598 or 414.655 is only permitted in accordance with Applicable Laws relating to health information privacy.

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 OHA and DHS for the purpose of administering the laws of Oregon.

f. In the event Contractor Discovers a security breach or has a reasonable belief there has been a security breach of its (i) Health Information System, (ii) any of its other computer systems, or there has been any other unauthorized disclosure, access, theft, or loss of any Clinical Record, personal information, record or other Protected Information whether in raw form or compilation thereof, that is in the possession, custody or control of Contractor, Contractor shall promptly, but in no event more than 48 hours after Contractor makes such Discovery, provide Legal Notice of such breach to OHA.

3. Access to Records

Contractor shall maintain its Records and allow access to all records, documents, information, systems and facilities in accordance with Ex. D, Sec. 15 to this Contract.

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 with Contractor in accordance with OAR 410-141-3520.

b. Contractor understands and agrees that neither OHA nor the Member receiving services are 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 (e.g., Third Party Resource recovery), Contractor 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 Patient Protection Affordable Care Act regarding the use of National Correct Coding Initiative.

e. Certain federal laws governing reimbursement of 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. This may also be the case with IHCPs who have not entered into Subcontracts with Contractor. These supplemental payments are outside the scope of this Contract and do not violate this Contract's prohibition on dual payments. Contractor shall maintain Encounter Data records and any other information relating thereto documenting Contractor's reimbursement to FQHCs, Rural Health Centers, and IHCPs, and provide such information to OHA upon request. Contractor shall also provide information documenting Contractor's reimbursement to non-participating IHCPs to OHA upon request.

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

h. Contractor shall reimburse Providers for all Covered Services delivered in integrated clinics by Health Care Professionals and other Providers.

i. Contractor shall support a Warm Handoff of a Member between levels or Episodes of Care.

5. Claims Payment

a. Claims that are subject to payment under this Contract by Contractor 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 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 410-141-3565.

b. Pursuant to OAR 410-141-3565, Contractor shall require Providers to submit all claims for Members to Contractor within four months of the Date of Service. However, Providers may, if necessary, submit their claims to Contractor within twelve (12) months from the date of Service under the following circumstances:

(1) Billing is delayed due to 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; or

(5) Other cases 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 have written policies and procedures for processing claims submitted for payment from any source. The policies and procedures 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 or 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 to determine whether a claim is Valid or invalid;

(5) Sending notice to the Member regarding Contractor's decision regarding the denial of a claim which must include information on the Member's Grievance and Appeal rights;

(6) Making information 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 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 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 Contractor receives a claim, as indicated by its date stamp thereon. Contractor and its Subcontractors may, by mutual agreement, agree to a different payment schedule provided that the minimum requirements required under 42 CFR § 447.45 and 42 CFR § 447.46 are met.

e. If a Non-Participating Provider who is enrolled with OHA is entitled to payment from Contractor for services provided to a Member, the Non-Participating Provider must bill Contractor in accordance with the requirements 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) 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 Members who are (i) enrolled with Contractor 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 IHCPs are paid at a rate equal to the rate negotiated between Contractor and the Participating Provider involved, which for a FQHC may not be less than the level and amount of payment which Contractor would make for the services if the services were furnished by a Participating Provider which is not a FQHC.

(2) Non-Participating IHCPs that are not a FQHC must be paid at a rate that is not less than the level and amount of payment which 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 IHCPs that are a FQHC must be paid at a rate equal to the amount of payment that Contractor would pay a FQHC that is a Participating Provider with respect to Contractor but is not an IHCP for such services.

g. Contractor shall make prompt payment to IHCPs including Indian Tribes, Tribal Organizations, or Urban Indian 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, Contractor shall not impose fees, premiums or similar charges on Indians served by an IHCP, Indian Health Services; an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through a Referral under Contract Health Services.

i. Contractor shall pay for Emergency Services that are performed by Non-Participating Providers as specified in OAR 410-141-3840.

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, frequency, and provided to OHA as may be specified by OHA from time to time; and

(4) In accordance with 42 CFR § 447.26(b) not make payment to Providers for Health Care-Acquired Conditions or Other Provider-Preventable Conditions that meet the following criteria:

(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 guidelines;

(c) Has a negative consequence for the Member;

(d) Is auditable; and

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

6. Medicare Payers and Providers

a. Contractor shall be an Affiliate of, or contract with, one or more entities that provide services as a Medicare Advantage plan serving FBDE Members throughout the entirety of Contractor's Service Area. Contractor shall demonstrate on a yearly basis that its Provider Network is adequate to provide both the Medicare and the Medicaid Covered Services to its FBDE Members. Contractor's Affiliated Medicare Advantage Plan or Affiliated DSN Plan(s) shall meet the network adequacy standards for such Plans as determined by CMS and set forth in the applicable rules and by 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 DSN 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 DSN 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 410-141-3865, Contractor shall coordinate, if Medically Appropriate, with Medicare payers and Providers for the care and benefits of Members who are eligible for both Medicaid and Medicare.

c. Contractor shall, in accordance with 42 CFR § 438.3(t):

(1) Have and maintain a Coordination of Benefits Agreement (COBA) with CMS;

(2) Follow CMS protocols as outlined in CMS guidance materials at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page; and

(3) Coordinate with the CMS national crossover contractor, Benefits Coordination & Recovery Center (BCRC), in order to participate in the automated crossover claims process for FBDE Members in Medicare, including where applicable Medicare Part D Plans and Medigap Plans.

(4) Follow posted file formats and connectivity protocols in CMS guidance materials.

(5) 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. Contractor shall have an automated crossover claims process in place for its Affiliated MA and DSN Plans. If Contractor did not have this system in place prior to Contract Year two (2021), Contractor shall provide to OHA no later than February 1, 2021, via Administrative Notice, written confirmation that the transition plan submitted in Contract Year One (2020) for Contractor and its Affiliated MA and DSN Plans has been fully implemented and that use of the system is fully in effect as of February 1, 2021.

e. In accordance with OAR 410-141-3565, when Contractor's Medicare-eligible Members receive Medicare Part A and Part B Covered Services from a Medicare Provider, Contractor shall pay, after adjudication with the applicable Medicare or Medicare Advantage Plan, the Medicare deductibles, coinsurance, and Co-Payments, in accordance with the State's methodology up to Medicare's or Contractor's allowable amounts, applicable to the Part A and Part B Covered Services received. Providers must be enrolled with Oregon Medicaid in order to receive such cost sharing payments. Accordingly, Contractor is obligated to pay such amounts only if the Medicare Provider is enrolled with Oregon Medicaid, and in such event, Contractor is obligated to pay such dual enrolled Provider regardless of whether such Provider is one of Contractor's Participating or Non-Participating Providers. Contractor should provide non-enrolled Providers with information about enrolling with Oregon Medicaid in order to receive the cost sharing payments. Contractor shall require Fee for Service Medicare Providers who provide services to FBDE Members to comply with OAR 410-120-1280(8)(i).

f. In the event Contractor's Medicare-eligible Members are provided with urgent care or emergency services by a Medicare Provider, Contractor shall pay for all such services not covered by Medicare even if (i) the provider is a Medicare provider not enrolled with Medicaid once the provider enrolls with Oregon Medicaid, or (ii) the provider is a Medicare provider enrolled with Oregon Medicaid but is not one of Contractor's Participating Providers.

g. Contractor is not responsible for Medicare deductibles, coinsurance and Co-Payments for Skilled Nursing Facility benefit days twenty-one (21) through one hundred (100).

h. If Contractor is an Affiliate of, or contracts with, an entity that provides services as a Medicare Advantage plan serving FBDE Members , Contractor may not impose cost-sharing requirements on FBDE Members and Qualified Medicare Beneficiaries that would exceed the amounts permitted by OHP if the Member is not enrolled in Contractor's Medicare Advantage plan.

i. Contractor shall provide an annual Report to OHA that identifies its affiliation or 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 template located on the CCO Contract Forms Website. Contractor shall promptly update its Affiliated Medicare Advantage Report prior to November 15 any time there has been a material change in Contractor's operations that would affect adequate capacity and services, and upon OHA's request. Contractor shall also provide all updated affiliation agreements or contracts annually as required as part of the MA affiliation report due November 15 of each Contract Year.

7. Eligibility Verification for Fully Dual Eligible Members

a. If Contractor is Affiliated with or contracted with a Medicare Advantage plan for 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. Contractor shall require its Providers to verify current Member eligibility using the Automated Voice Response system, 270/271 Health Care Eligibility Benefit Inquiry and Response transactions, or the MMIS Web Portal.

8. All Payer All Claims Reporting Program

Contractor shall participate in the All Payers All Claims (APAC) Reporting Program established by OHA in accordance with its authority under ORS 442.373 and as implemented by OAR 409-025-0100 through 409-025-0190. Data submitted under this Contract may be used by OHA for the purposes identified in ORS 442.373 and disclosed in accordance with OAR 409-025-0160 and OAR 409-025-0170. Providing Encounter Data to OHA in accordance with this Contract will partially fulfill Contractor's responsibility for APAC reporting. Contractor's submission of Payment Arrangement File data to APAC, together with the submission of its Encounter Data, will wholly fulfill Contractor's responsibility for APAC reporting. Additional information regarding compliance and enforcement 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: Valid Encounter Claims Data

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 submission of 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 410-141-3565 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. Sections 9 through 15 of this Ex. B, Part 8, set forth the criteria, processes, and high-level obligations with which Contractor shall 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 submit two different Valid Encounter Data sets at least once per calendar month by no later than the Final Submission Month. One Valid Encounter Data set will include Non-Pharmacy 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 (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. Contractor shall submit all Valid Encounter Data in accordance with OAR 410-141-3570 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: https://www.oregon.gov/oha/HSD/OHP/Pages/Encounter-Data.aspx.

d. In accordance with section 1903(m)(2)(A)(xi) of the Social Security Act, Contractor shall maintain all Encounter Data in a manner that is sufficient to identify the actual Provider who delivered the services to the Member.

e. All Valid Encounter Data must be submitted in the timeframes and meet the criteria set forth in OAR 410-141-3570. 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 OHA is unable to process Encounter Data due to missing or erroneous information, Contractor shall correct errors in such Encounter Data as directed by OHA.

g. If Contractor fails to submit all of its Adjudicated Encounter Data within forty-five (45) days of the Claims Adjudication date, Contractor shall 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 410-141-3570, 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 410-141-3570, acceptable reasons for a delay in submission of Encounter Data are any one of the following:

(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; and

(6) OHA recognized system issues preventing timely submission of Encounter Data including systems issues preventing timely submission to the All Payer All Claims database.

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 Encounter Data submitted by Contractor. 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 Encounter Data submitted by Contractor. 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. l 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.

10. 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 410-141-3570, 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 410-141-3570, and 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 shall first become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transaction 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 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 on the CCO Contract Forms Website.

11. 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 Non-Pharmacy Encounter Data to OHA within 45 days after the Claims Adjudication date. If Contractor fails to provide OHA with all of its Non-Pharmacy

Encounter Data within forty-five (45) days after the Claims Adjudication date or if the submissions of duplicate claims or other errors exceed five percent (5%) per month, OHA may 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. 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 identified in such notification is referred to as "Encounter Data Requiring Correction." OHA will not necessarily notify Contractor of report errors.

c. 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 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 within sixty-three (63) days of OHA notification, or the shorter period of time as indicated in OHA's notice of Encounter Data Requiring Correction, OHA may exercise its rights under Sec. 9, Par. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

12. Encounter Pharmacy Data

a. In accordance with Sec. 9, Paras. a.-f, and Sec. 10 above of this Ex. B, Part 8 and OAR 410-141-3570, Contractor shall submit to OHA all paid Pharmacy Encounter Data within forty-five (45) days after the Claims Adjudication Date. If Contractor's Pharmacy Encounter Data is submitted more than forty-five (45) days after the Claims Adjudication date or if the submission of duplicate claims or other errors exceed five percent (5%) per month, OHA may 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. 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.ncpdp.org/.

c. 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 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 may exercise its rights under Sec. 9, Par. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

13. 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 410-141-3570 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 410-141-3570, 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 Contractor shall 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 SubPara. (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.

14. Drug Rebate Program

a. Contractor acknowledges that OHA is eligible for 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) section 1206 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and OAR 410-141-3570.

b. OHA will retain all rebates collected from such manufacturers, unless the drug is subject to discounts under Section 340B of the Public Health Service Act.

c. In the event Contractor receives (either directly or from Contractor's PBM) any rebates from a drug manufacturer to which OHA is entitled, Contractor shall report any and all such rebates received. Such rebates shall be reported on Exhibit L Financial Report Template (See Sec. 1, Para. a., Sub. Para. (2) of Ex. L of this Contract).

d. Contractor shall report to OHA sufficient data and information to enable OHA to secure federal drug rebates for all utilization and administration of any covered Outpatient drugs provided to Members. 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, biologics, and other Provider administered products dispensed to Members consistent with all Applicable Laws, including, without limitation, 42 Part 447 and OAR Chapter 410, Divisions 120 and 121; and

(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 and 12 above of this Ex. B, Part 8 and this Sec.14, Ex. B, Part 8, Contractor shall also report on a timely periodic basis to OHA any other data as deemed necessary and as specified by the Secretary of Health and Human Services.

15. 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 Contractor for review and resolution. Contractor shall assist OHA in the resolution process as follows:

(1) 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) If Contractor agrees with the Invoiced Rebate Dispute that an error has been made, Contractor shall correct and re-submit the Encounter Data to OHA, within 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 send the details of the disagreement to OHA's Encounter Data Liaison, within forty-five (45) days of receipt of the Invoiced Rebate Dispute.

16. Third Party Liability and Personal Injury Liens

a. If a Member has other insurance coverage available for payment of Covered Services, such other insurance is primary to the coverage provided by Contractor under this Contract. Accordingly, the Other Primary Insurance must be exhausted prior to Contractor making any payment for any Covered Services. If the Member has any liability for cost-sharing under the Other Primary

Insurance, Contractor shall pay the amount of the Member's cost-sharing to the Other Primary Insurance.

b. If Contractor recovers from a Third-Party Payer the fees Contractor paid for Covered Services provided to a Member, Contractor will have the right to retain those recoveries. Contractor shall report to OHA all amounts recovered from such Third-Party Payers. Reporting shall be made quarterly using the Exhibit L Financial Reporting Template.

c. Contractor shall take all reasonable actions to pursue recovery of Third-Party Liability for Covered Services provided 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, at which point, OHA shall have the right to pursue recovery.

d. 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 or its designee will take all reasonable actions to pursue recovery of such amounts from the applicable Third-Party Payer. Contractor shall cooperate in good faith with OHA in any efforts undertaken by OHA to recover funds from Third Party Payers.

e. Contractor shall develop and implement written policies and procedures regarding Third-Party Liability recovery in a TPLR P&P Guidebook. The TPLR P&P Guidebook must include, at a minimum, all of the following:

(1) The requirement for Providers and Subcontractors to request and obtain TPL information from the 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 in the 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 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) The requirement of Contractor to adjust Encounter Data to reflect the amount received or recovered from the 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 shall 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 8, 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 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. 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 410-141-3810, and ORS 743B.470, 659.830, 416.510 to 416.610. OHA will notify Contractor within thirty (30) days from submission of the approval status of its TPLR P&P Guidebook or if additional time is needed for review. 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 shall include in its Member Handbook the same content from its OHA approved TPLR P&P Guidebook regarding the obligation of Members to provide information to, and cooperate with, Contractor in order for Contractor to meet its obligations under this Sec. 16, Ex. B, Part 8. The content regarding such Member obligations shall, when included in the Member Handbook, conform to the accessibility requirements described in Member Communication Requirements located on the CCO Contract Forms Website. Contractor shall provide its Members with the applicable TPLR content, or an updated Member Handbook with the applicable TPLR content included, as follows:

(1) To all Members within thirty (30) days after receipt of OHA's annual written approval of the TPLR P&P Guidebook;

(2) To Potential Members before and during Enrollment; and

(3) To all Members within thirty (30) days after receipt of OHA's written approval any material changes to the TPLR P&P Guidebook.

i. If Contractor, or its 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 compare its monthly 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 shall document and report any and all such matches within thirty (30) days of the date of identification. Reporting must be made online at the following URL: https://apps.oregon.gov/dhs/opar#.

(1) Any information about PIP motor vehicle coverage should be reported to:

https://apps.oregon.gov/OPAR/PIL/.

j. If Contractor receives information that a Member has Other Insurance outside of OHP, Contractor shall report such coverage to OHA, within thirty (30) days of Contractor's receipt of notice of the Other Primary Insurance. Reporting must be made online at the following URL: https://apps.oregon.gov/dhs/opar#.

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

(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. Contractor shall document and 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 Payers. Such data must be documented in a manner that allows reconciliation and audit of reported recoveries and adjusted encounter claims data. Contractor shall make such documents available to OHA or its designee(s), as may be requested from time to time.

o. Contractor shall report all Third Party Liability recoveries to the OHP Coordination of Benefits and Subrogation Recovery Section on the 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. Contractor shall adjust any Encounter Data within the timeframes specified under Secs. 9-12 above of this Ex. B, Part 8 to reflect Third Party Liability recoveries for such Encounter Data.

q. OHA will provide Contractor 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. Contractor agrees to: (i) provide OHA with all Third Party Liability and eligibility information in order to assist in the pursuit of financial recovery and (ii) respond in a timely manner to any other requests for information.

17. Personal Injury Liens

a. The Personal Injury Liens Unit of the Office of Payment Accuracy and Recovery of DHS is authorized pursuant to OAR 461-195-0303 to administer the Personal Injury Lien program for OHA and DHS.

b. 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.

c. Contractor shall 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 shall 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: https://apps.oregon.gov/OPAR/PIL/.

(2) After completing its report, Contractor is encouraged to print and maintain a copy of such Report in its files.

d. 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.

e. Contractor shall obtain a written lien assignment from OHA or its designee prior to any attempt to seek reimbursement from a Member's, or a Member's beneficiary's, proceeds arising from an injury or death for which a third-party is financially legally liable. Contractor shall, 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 shall 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 has no authority to sell or otherwise transfer its rights in the assigned lien, except to OHA or its designee.

f. When Contractor is aware of a Third Party that may be legally liable for medical expenses for Member, Contractor shall request a lien assignment by completing the online request located at the following URL: https://apps.oregon.gov/OPAR/PIL/. At a minimum, Contractor shall provide the following information, if known, when requesting a lien assignment:

(1) Contractor's 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 compromised, 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 compromised, 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 compromised, closed, or terminated liens:

(a) The date of any settlement or judgment, if known;

(b) The gross amount of any settlement or judgment, if known;

(c) The amount received from any liable third-party, and

(6) Any other information that PIL may request.

h. Contractor shall create Lien Release and Lien Filing Templates 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 and Lien Filing Templates must conform with the requirements of ORS 416.560, and, notwithstanding the authority to resolve a lien, Contractor has no other the authority to act on behalf of the State beyond the assigned lien.

i. Contractor shall provide its Lien Release and Lien Filing Templates to PIL annually for review and approval prior to use. The Lien Release and Lien Filing Templates shall be provided to the PIL Unit, via Administrative Notice, 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 or Lien Filing Template or both for failure to comply with this Contract or Applicable Law or (or both), Contractor shall, in order to remedy the deficiencies in such Templates, 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 or Lien Filing Template or both after approval by the PIL Unit. Contractor shall 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. i. above of this Sec**.** 17, Ex. B, Part 8.

k. Contractor does not have the right to refuse to provide Covered Services and must not permit any of its Participating Providers to refuse to provide Covered Services to a Member because of potential Third Party Liability for payment for the Covered Service.

l. Contractor shall obtain the prior written approval of the PIL Unit before compromising any assigned lien. The PIL Unit will coordinate with Contractor or the plaintiff's attorney or both in compromising the PIL Unit's lien or Contractor's lien or both. 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. In the event a Member or a third-party initiates litigation to reduce or eliminate Contractor's assigned lien, or in the event Contractor determines litigation is required to defend or pursue Contractor's assigned lien, Contractor shall reassign the assigned lien to OHA as follows:

(1) If a Member or a third-party initiates the litigation, Contractor shall promptly, but in no case later than ten (10) days after learning of such initiation, notify OHA via Administrative Notice.

(2) Contractor shall cooperate with the PIL Unit 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.

(3) Contractor's designated officer(s) shall execute the assignment of lien form provided by the PIL Unit and located on the CCO Contract Forms Website.

(4) Contractor shall permit the PIL Unit to communicate and work directly with any Subcontractor in order to efficiently undertake and manage any TPL activity.

(5) Contractor and its Subcontractor(s) shall enter into any data-sharing agreements as may be requested by the PIL Unit or OHA or both.

p. 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 Contractor, OHA may retroactively Disenroll a Member to the time the Member acquired the Other Primary Insurance, pursuant to OAR 410-141-3080(3)(e)(A) or 410-141-3810. When a Member is retroactively Disenrolled under this Para. p, Sec. 17, Ex. B, Part 8 of this Contract, OHA will recoup all Payments to Contractor for the Member after the effective date of the Disenrollment. Contractor and its Providers do not have the right to collect, and shall not attempt to collect, from a Member (or any financially responsible Member Representative) or any Third-Party Payer, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

q. 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.

r. Where Medicare and Contractor have paid for services, and the amount available from the Third Party Payer is not sufficient to fully reimburse both programs for their respective claims, the Third Party Payer must first reimburse Medicare the full amount of its claim before any other entity, including Contractor or its Subcontractors, may be paid.

s. If the Third Party Payer has reimbursed Contractor, or its Participating Providers, or Subcontractors, 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.

t. If a Member, after receiving payment from the Third Party Payer, has reimbursed Contractor, or its Subcontractors, or Participating Providers, 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 Member.

u. Contractor shall 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 Exhibit L Quarterly Financial Report submitted to OHA.

v. When engaging in Third Party Liability recovery actions, Contractor shall comply with, and require Agents to comply with, the federal confidentiality requirements described in Sec. 6, Ex. E of this Contract and any other additional confidentiality obligations required under this Contract and State law. Contractor agrees 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 Third Party recovery actions a purpose that is directly connected with the administration of the Medicaid program.

18. Disclosure of Ownership Interests

a. Contractor shall provide OHA with the disclosures required in this Sec. 18, Ex. B, Part 8 in accordance with the details set forth in Paras. b-c below of this Sec. 18, Ex. B, Part 8. The disclosures under Sec. 18-19, Ex. B, Part 8 are subject to 42 CFR §§ 455.100- 455.106, 42 CFR §§ 438.602(c) and 438.608(c), and OAR 410-120-1260 and required to be made to OHA by Contractor and if requested, furnished to CMS and HHS.

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

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

(2) Date of birth and Social Security Number for every individual disclosed under Sub. Para. (1) above of this Sec. 18, Ex. B, Part 8.

(3) The FEIN or other tax identification number 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) The name, address, date of birth, and social security number of Contractor's Managing Employee(s).

(8) 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's involvement in any program under Medicare, Medicaid, or other federal services program since the inception of those programs.

(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) Upon amendment, Renewal, or extension of this Contract: To OHA via Administrative Notice.

(2) 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: To OHA via Administrative Notice, and

(3) 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 shall 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 for (i) and (iii) and within ten (10) days of the date of change for (ii) and must identify the new address or TIN (or both) and the date upon which such change(s) became effective.

19. 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 shall 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 shall 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 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 shall 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.

20. Certain Changes in Control Requiring Pre-Approval from OHA

a. In the event a Person who has a Controlling interest in Contractor desires to give up their Control therein, such person shall provide OHA with no less than thirty (30) days prior written notice, which shall be deemed Protected Information under this Contract until the transaction is concluded (OAR 410-141-5320). Any such change in control shall also require the prior written consent of OHA (OAR 410-141-5325). Without limiting the generality of the definition of "Control" under this Contract or the facts or circumstances that may otherwise constitute a change in Control of Contractor, the following transactions shall be presumed to involve a change in Control of a Contractor: (i) the consolidation or merger of Contractor with another, (ii) a reorganization of Contractor, (iii) the acquisition by another of ten percent (10%) or more of Contractor's voting securities or the voting securities of any corporation or other legal entity that directly or indirectly Controls Contractor, and (iv) the acquisition by another of all or substantially all of the assets or operations of Contractor. Notwithstanding the foregoing, Contractor shall have the right to apply to OHA for a determination that a particular transaction, on the facts and for the reasons presented, will not result in in a change in Control (OAR 410-141-5405 and 410-141-5410) and therefore is not subject to prior written notice to and approval by OHA (OAR 410-141-5320 and 410-141-5325).

b. Contractor shall 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 Department of Consumer and Business Services or as a Medicare Advantage plan within fourteen (14) days of the change and for any change in Federal Tax Identification Number, within ten (10) days of the date of change.

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

d. Contractor understands and agrees that Contractor is the legal entity obligated under this Contract and that OHA is engaging the expertise, experience, judgment, representations and warranties, and certifications of Contractor set forth in this Contract and in the Application for this Contract. Contractor may not transfer, Subcontract, assign 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 no less than 120 days prior to the effective date of any such transfer, Subcontract, assignment or sale, except as otherwise provided in Ex. B, Part 4, Sec. 14 of this Contract governing adjustments in Service Area or Enrollment and Ex. D, Sec. 20.

e. As a condition precedent to obtaining OHA's approval of a transfer, Subcontract, assignment, or sale under Para. d above of this Sec. 20, Ex. B, Part 8, Contractor shall provide to OHA, via Administrative Notice, 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.

(2) A representation and warranty signed and dated by both the proposed New Entity and Contractor, in a form acceptable to OHA, that represents and warrants that the policies,

procedures and processes issued by Contractor will be those policies, procedures, or processes provided to, and if required, approved by, OHA by 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 Entity cannot provide representations and warranties required under this subsection, OHA shall be provided with the new policies, procedures and processes proposed by the proposed New Entity for review consistent with the requirements of this Contract.

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

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

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

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

h. Contractor shall reimburse OHA for all legal fees reasonably incurred by OHA in reviewing the proposed transfer, Subcontract, assignment or sale, and in negotiating and drafting appropriate documentation.

21. Subrogation

Contractor agrees, to subrogate to OHA any and all claims Contractor has or may have against 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, distributor, laboratories, or any other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products. Nothing in this provision prevents the State of Oregon from working with Contractor to release its right to subrogation in a particular case.

22. Contractor's Governing Board

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

Exhibit B – Statement of Work – Part 9 – Program Integrity

1. Monitoring and Compliance Review - Overview

a. OHA is responsible for Monitoring Contractor's compliance with the terms and conditions of this Contract and all Applicable Laws related thereto. Methods of 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 documents and any other source of relevant information.

b. If, after conducting an audit or other compliance review, Contractor's compliance cannot be determined, or if OHA determines that Contractor has breached the terms or conditions (or both) of this Contract, OHA will have the right to impose Sanctions, including civil money penalties.

c. OHA will Monitor Contractor's performance, trends and emerging issues on a monthly basis and provide reports to CMS quarterly. OHA must report to CMS any issues impacting 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, Contractor will be deemed to be in breach of this Contract. In such event, OHA will have the right to impose Sanctions, which may include requiring Contractor to develop and implement a Corrective Action Plan 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 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 Sec. 2, Ex. B, Part 9, or failed to comply with any of the other terms or conditions of this Contract. As specified in Ex. B, Part 4, Sec. 11 a. (7), a breach of the requirements of this Contract by a Subcontractor shall be deemed a breach of Contractor and Contractor shall be liable for such Subcontractor breach.

b. Without limiting Para. a above, of this Sec. 2, Ex. B, Part 9, OHA shall have the right, pursuant to 42 CFR § 438.700, to impose Sanctions when Contractor breaches this Contract as follows:

(1) Fails to authorize or otherwise substantially provide Medically Appropriate services that Contractor is required to authorize and provide to a Member 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 this Contract or applicable State or federal law;

(a) Contractor shall not charge Members any Premiums for any services provided pursuant to this Contract.

(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, disability, health status, or need for health care services. Acts that may be evidence of discrimination include, but are not limited to: (i) Disenrollment of, or refusal to reenroll, a Member, except

as permitted under this Contract, (ii) any practice that would reasonably be expected to discourage Enrollment, or (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;

(4) Misrepresents or falsifies any information that is required to be submitted to CMS, the State, or their designees under this Contract, including but not limited to any such information submitted in: (i) or in connection with 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, or (iv) any other 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 required under Ex. L of this Contract;

(8) Fails to maintain a Participating Provider Network 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, 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 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, orrecord keeping and reporting requirements;

(11) Fails to pay for Emergency Services and post-emergency stabilization services or Urgent Care Services as required under this Contract;

(12) Fails to make timely claims payments to Providers or fails to provide timely approval of authorization requests;

(13) Fails to disclose required ownership information or fails to supply requested information to OHA relating to Contractor's Subcontractors or suppliers of goods and services;

(14) Fails to submit accurate, complete, and truthful Pharmacy or Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;

(15) Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;

(16) Violates of 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) 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. In the event Contractor is in breach of this Contract, OHA will have the right to impose one or more Sanctions or any combination of Sanctions for the same 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 civil money penalty, while also requiring Contractor to develop and implement of a 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 141-410-3530, which may include, without limitation:

(a) Assessment of a recovery amount equal to one percent (1%) of Contractor's last total monthly CapitationPayment 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

OHA may impose civil money penalties in the amounts authorized in 42 CFR § 438.704 as follows.

a. 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 provide Medically Appropriate services to a Member that Contractor is required to provide under this Contract or applicable State or federal law.

(2) 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.

(4) Distributed directly or indirectly through any Subcontractor, Agent, or independent contractor, Marketing Materials that were not approved by the State or that contained false or materially misleading information

b. 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. Evidence of discrimination may include, but is not limited to, 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; or

(2) Misrepresented or falsified any information that 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. The limit is $15,000 for each Member OHA determines was not 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.

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. d, 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. 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, (ii) Contractor has engaged in any conduct described in 42 CFR § 438.700 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 (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 OHA 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.

b. 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 without cause and notify Members of their right to Disenroll without cause;

c. OHA will not delay the imposition of temporary management mechanisms to provide for Administrative Review before imposing this Sanction; and

d. OHA will not terminate temporary management mechanisms until it determines that Contractor can ensure that the conduct that resulted in a breach or repeated breaches of this Contract will not reoccur.

6. Corrective Action Plan

a. If OHA determines that Contractor's breach of this Contract requires Contractor to develop and implement a CAP, the CAP shall include, at a minimum, all of the following:

(1) A description of the issues and factors which contributed to Contractor's breach ;

(2) Designation of one Person within Contractor's organization who is charged with 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 its breach of this Contract;

(4) A timeline that identifies when Contractor shall begin implementing such specific actions and a date certain by which Contractor shall 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 access to care issues that were caused as a result of the breach; and

(6) If the breach was a result of a Subcontractor's failure to comply with the terms and conditions of this Contract, a description of the activities, processes, and evaluation criteria Contractor intends undertake for the purpose of Monitoring Subcontractor performance and compliance to prevent reoccurrence.

b. 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. 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.

7. Civil Money Penalties: OAR 410-141-3530

a. Contractor acknowledges that any failure to meet 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 (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 410-141-3530, OHA has the right to impose civil money penalties as follows:

(1)	Failure to terminate a Provider who becomes ineligible to participate in Medicaid	$500 per occurrence in addition to $250 per day until the Provider is terminated
(2)	Failure to report the "for cause" termination of a Provider from Contractor's network within timeframes specified in Contract	$250 per occurrence
(3)	Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination to a Member within the timeframe defined in Contract and OAR	$1,000 per occurrence
(4)	Delegation of an Appeal to a Subcontractor or Delegated entity in violation of Contract terms	$1,000 per occurrence
(5)	Failure to provide a timely response to a Provider's request for Prior Authorization within the timeframes defined in OAR 410-141-3835	$250 per occurrence
(6)	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
(7)	Failure to adjust an Encounter Data entry to reflect a financial Recoupment from a Provider	$50 per claim
(8)	Failure to timely submit a reporting deliverable by the due date specified in Contract	$250 per day for each day the deliverable is late
(9)	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
(10)	Failure to timely submit quarterly and annual audited and unaudited financial statements	$250 per day for each day the deliverable is late
(11)	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
(12)	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 Contractor failed to report the TPL information to OHA

b. In accordance with OAR 410-141-3530, nothing in this Sec. 7, Ex. B, Part.9 or in Sec. 4 above of this Ex. B. Part 9 prohibits OHA from imposing civil money penalties for any other act or failure to act by Contractor that constitutes a breach of this Contract.

c. If OHA elects to impose a civil money penalty for a breach not listed this Sec. 7, Ex. B, Part 9 or in Sec. 4 above of this Ex. B, Part 9 the specific amount of the penalty will be determined in accordance with OAR 410-141-3530.

8. Sanction Process

a. In the event OHA determines Contractor will be subject to one or more Sanctions, OHA will provide Contractor with Legal Notice of its intent to impose Sanction(s). The Legal Notice will explain the factual basis for the Sanction(s), reference to the applicable Section(s) of this Contract or applicable federal, State law that has been violated, identify the actions to be undertaken by Contractor to remedy the breach, and state 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.

b. In cases 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 before a requested Administrative Review is commenced or completed .

c. Contractor shall 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 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 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 receiving Legal Notice of the Sanction, OHA will setoff the full sum of the civil money penalty from Contractor's future Payment(s) or as otherwise provided under this Contract, until the 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. 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 decisions under this Contract.

9. 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 or lifted a Sanction, including civil money penalties, on Contractor.

10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures.

a. 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 a Fraud, Waste, and Abuse (FWA) prevention and detection program and policies and procedures that ensure compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510; and (ii) annually creating a plan for implementing its policies and procedures.

b. 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.

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

a. Contractor shall develop a FWA Prevention Handbook wherein Contractor sets forth its written policies and procedures in accordance with the requirements set forth in 42 CFR §§ 438.600-438.610, 42 CFR § 433.116, 42 CFR § 438.214, 438.808, 42 CFR §§ 455.20, 455.104 through 455.106, 42 CFR § 1002, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510 that will enable Contractor to detect and prevent potential Fraud, Waste, and Abuse activities that have been engaged in by its employees, Subcontractors, Participating Providers, Members, and other third parties.

b. Contractor's FWA Prevention Handbook must include, at a minimum, all of the following:

(1) 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 the written policies and procedures 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) Establishment and identification of the members of a Regulatory Compliance Committee, which shall include Contractor's Chief Compliance Officer, senior level management employees, and members of the Board of Directors. The Regulatory Compliance Committee will be responsible for overseeing Contractor's Fraud, Waste, and Abuse prevention program and compliance with the 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 statement or narrative that articulates Contractor's commitment to complying with the terms and conditions set forth in Secs. 1-18 of this Ex. B, Part 9 and all other applicable State and federal laws;

(5) 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) 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. (7) 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) Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees, Participating Providers, or Subcontractors who have violated Fraud, Waste and Abuse policies and procedures and any other applicable State and federal laws;

(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 Participating Providers and Subcontractors 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, Participating 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 an accounting or system error.

(a) 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 to Contractor within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment.

(b) 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.

(c) 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 Ex. B, Part 9, Contractor shall develop and maintain a procedure for accurately reporting all Overpayments on its quarterly and annual Financial Reports as required under Sec. 1, Para. a., Sub-Para. (2), Ex. L. Contractor's Ex. L Report must include 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) A Member Grievance resolution process protecting the anonymity of Members who file complaints and to protect Members 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 Participating Provider's or Subcontractor's circumstances that may affect the Provider's or Subcontractor'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 to OHA within thirty (30) days of receipt of such information.

c. Contractor shall provide its FWA Prevention Handbook to all employees or otherwise include its complete contents in Contractor's employee Handbook.

d. Contractor shall 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 report Fraud, Waste, and Abuse anonymously, and to be protected under applicable Whistleblower laws.

12. Annual FWA Prevention Plan

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's Annual FWA Prevention Plan, must include, at a minimum, written plans and procedures for all of the following activities:

(1) 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 FWA Prevention Handbook and Annual FWA Prevention Plan

a. Contractor shall provide to OHA, via Administrative Notice, its FWA Prevention Handbook and Annual FWA Prevention Plan 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. OHA will notify Contractor, via Administrative Notice to Contractor's Contract Administrator, within sixty (60) days of receipt of the compliance status of its FWA Prevention Handbook and Annual FWA Prevention Plan. 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, follow the process set forth in Sec. 5, Ex. D of this Contract. In addition, if 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 shall review and update its Annual FWA Prevention Plan and FWA Prevention Handbook annually and provide to OHA annually, via Administrative Notice, copies of such documents for OHA's review and approval as set forth in this Sec. 13, Ex. B, Part 9. In the event Contractor has not made any changes to its FWA Prevention Handbook since it was last approved by OHA, Contractor may instead submit an attestation that no changes have been made since it was last approved, provided that such approval was made by OHA in the Contract Year immediately preceding the Contract Year in which Contractor desires to submit its attestation. In no event, however, shall Contractor submit an attestation in two consecutive Contract Years, even if Contractor did not make any changes in its FWA Prevention Handbook since the submission of the previous year's attestation. 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 also submit such Plan and Handbook for subsequent review and approval as follows:

(1) To OHA, via Administrative Notice, upon any significant revisions by Contractor, regardless of whether such changes are made prior or subsequent to annual approval by OHA, or prior to Contractor's final adoption of 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 sixty (60) 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) To OHA anytime upon OHA request. Contractor shall provide OHA with the requested Annual FWA Prevention Plan or FWA Prevention Handbook, or both, within thirty (30) days of OHA request in the manner requested by OHA. OHA will notify Contractor within sixty (60) 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.

14. OHA and Contractor Audits of Network Providers

a. If OHA conducts an audit of Contractor's Participating Providers, or Subcontractors, or the Providers' or Subcontractors' 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 and Subcontractors. OHA will provide Contractor's Contract Administrator with Administrative Notice of its findings and its decision relating to means of and timeframe for recovery of any finding of Overpayment.

b. OHA will provide Contractor's Contract Administrator and Chief Compliance Officer with Administrative Notice of its audit findings and its decision relating to means of and timeframe for recovery of any finding of Overpayment. OHA recovery from Contractor of Overpayments identified by an OHA audit of Contractor's Participating Providers or Subcontractors will follow the process outlined in OAR 407-120-1505. Contractor may appeal an Overpayment determination by submitting a written request to OHA's Office of Program Integrity (OPI) within 30 calendar days from the postmark date of the Final Audit Report. Appeals will be conducted by OPI in the manner described in OAR 407-120-1505.

c. In accordance with OAR 407-120-1505, Contractor may be liable for up to triple the total Overpayment amount of the final audit report if OHA, in the course of an audit of Contractor's Participating Providers or Subcontractors, discovers the Provider has continued the same or similar improper billing practices as established, or upheld if appealed, in a previously published final audit report by OPI or has been warned in writing by DHS, OHA, OPI, or DOJ about the same or similar improper billing practices.

d. If OHA conducts an audit of Contractor's Providers or Subcontractor or the Providers' or Subcontractors' 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.

e. If Contractor or its Subcontractors conduct audits of Contractor's Providers or Providers' Encounter Data that results in a finding of Overpayment, Contractor shall 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.

f. Recoveries that are retained by Contractor shall be reported to OHA as set forth in this Ex. B, Part 9 and Ex. L.

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 shall also comply with all of the procedures for managing and otherwise processing the recovery of such Overpayments as follows:

a. Contractor shall adjust, void or replace, as appropriate, each Encounter claim to reflect the Valid Encounter claim once Contractor has recovered Overpayment within thirty (30) days of identifying such Overpayment in accordance with OAR 410-141-3570 and Secs. 10-12 of Ex B, Part 8.

b. Contractor shall maintain records of Contractor's actions and Subcontractors' actions related to the recovery of Overpayments made to Providers, Subcontractors, or other third parties. Such records maintenance must be made in accordance with and made available to OHA 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. Examples of 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-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.

e. Contractor does not have the right, under this Sec. 15 of this Ex. B, Part 9, to retain any 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 Acts (ii) a judgment or settlement arising out of or related to litigation involving claims of Fraud, or (iii) through government investigations, such as amounts recovered by OPI or DOJ's MFCU or any other State or federal governmental entity, regardless of whether Contractor referred the matter to such parties.

16. Examples of Fraud, Waste, and Abuse

a. Examples of Fraud, Waste, and Abuse include, without limitation, any one, combination of, or all of the following:

(1) Providers, other CCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.

(2) Providers, other CCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.

(3) Providers, other CCOs, or Subcontractors intentionally or recklessly billed Contractor or OHA more than the Usual Charge to non-Medicaid Recipients or other insurance programs.

(4) Providers, other CCOs, or Subcontractors altered, falsified, or destroyed Clinical Records for any purpose, including, without limitation, for the purpose of artificially inflating or obscuring such Provider's own compliance rating or collecting Medicaid payments otherwise not due. This includes any intentional misrepresentation or omission of fact(s) that 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) Providers, other CCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.

(6) Providers, other CCOs, or Subcontractors that intentionally or recklessly misrepresent medical information to justify Referrals to other networks or out-of-network Providers when such parties are obligated to provide the care themselves.

(7) Providers, other CCOs, Subcontractors that intentionally fail to render Medically Appropriate Covered Services that they are obligated to provide to Members under this Contract, any Subcontract with Contractor, or Applicable Law.

(8) Providers, 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-for-Service charge and Contractor's payment to the Provider, in violation of Applicable Law.

(9) Providers, other CCOs, or Subcontractors intentionally or recklessly submitted a claim for payment when such party knew the claim: (i) had already been paid by OHA or Contractor, (ii) had already been paid by another source.

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

(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) Evidence of corruption in the Enrollment and Disenrollment process, including efforts of Contractor employees, State employees, other CCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from Contractor or any other CCO.

(13) Attempts by any individual, including Contractor's employees, Providers, Subcontractors, other CCOs, Contractor, or State employees or elected officials, to solicit kickbacks or bribes. For illustrative purposes, the offer of a bribe or kickback in connection with placing a Member into Carve-Out Services, or for performing any service that such persons are

required to provide under the terms of such persons' employment, this Contract, or Applicable Law.

17. Contractor's Obligations to Report Fraud, Waste and Abuse

a. In addition to its reporting requirements with respect to Providers under this Ex. B, Part 9, Contractor shall 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. Using the template provided by OHA (located on the CCO Contract Forms Website), and in accordance with Contractor's FWA Prevention Handbook and Annual FWA Prevention Plan, Contractor shall submit to OHA quarterly and annual reports of all audits performed. The Annual and Quarterly FWA Audit Report must include all data points listed in the template, 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.

(1) The Annual FWA Audit Report is due January 31 of each Contract Year and must be provided to OHA via Administrative Notice; and

(2) The Quarterly FWA Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.

c. Using the template provided by OHA (located on the CCO Contract Forms Website), Contractor shall submit to OHA, via Administrative Notice, an annual and quarterly summary report of FWA Referrals and cases investigated. The report must include, regardless of Contractor's own suspicions or lack thereof, any incident with any of the characteristics listed in Sec. 16 of this Ex. B, Part 9. The report must include all of Contractor's open and closed preliminary investigations of suspected and credible cases.

(1) The annual FWA Referrals and Investigations Report is due January 31 of each Contract Year following the reporting year and must be provided to OHA via Administrative Notice.

(2) The quarterly FWA Referrals and Investigations Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.

d. In addition to the annual and quarterly summary of FWA Referrals and Investigations, Contractor shall report all suspected cases of Fraud, Waste, and Abuse, including suspected Fraud committed by its employees, Participating Providers, Subcontractors, Members, or any other third parties to OPI and DOJ's MFCU. Reporting must 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.

e. In addition to the annual and quarterly summary of FWA Referrals and Investigations, Contractor shall report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Sec. 16, 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 shall 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) Contractor shall provide copies of reports or other documentation requested by MFCU, OPI, 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, OPI, or their designees;

(2) Contractor shall permit MFCU, OPI, 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) Contractor shall cooperate in good faithwith the MFCU, OPI, as well as their respective designees, or any or all of them, during any investigation of Fraud, Waste, or Abuse; and

(4) 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 OPI 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. Where to Report a Case of Fraud or Abuse by a Provider

(1) Contractor, if made aware of any suspected Fraud, Waste, or Abuse by a Participating Provider, Subcontractor, or its own employees, must report the incident to MFCU and OPI 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 Office of Program Integrity (OPI)
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

(2) Contractor shall include the above contact information for MFCU and OPI in its FWA Prevention Handbook and its Member Handbook.

i. Where to 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) must promptly report the incident to the DHS Fraud Investigation Unit (FIU). Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

DHS Fraud Investigation Unit
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

(2) Contractor shall include the above contact information for the DHS Fraud Investigation Unit in its FWA Prevention Handbook and its Member Handbook.

18. Assessment of Compliance Activities

a. Contractor shall 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. This Annual FWA Assessment Report must include an introductory narrative of Contractor's efforts over the prior Contract Year and their effectiveness.

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

(1) Identify the number of preliminary investigations by Contractor and the final number of Referrals to OPI or MFCU or both;

(2) Identify the number of Subcontractor and Participating 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 its Providers and Subcontractors;

(4) Compliance and Fraud, Waste, and Abuse prevention activities that were performed during the reporting year. Contractor shall include in its report: (i) a review of the Provider audit activities 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, Participating 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, DOJ's, MFCU, or CMS on improving the compliance activities performed by Contractor; (v) a sample of the Service Verification Letters mailed to Members, and (vi) a summary report on: (A) the number of Service Verification letters sent, (B) how Members were selected to receive such Letters, (C) Member response rates, (D) the frequency of mailings, including all dates on which such Letters were mailed, (E) the results of the efforts, and (F) 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.

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Exhibit B – Statement of Work – Part 10 – Transformation Reporting, Performance Measures and 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 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 The foregoing work requires Contractor to produce and provide to OHA three separate deliverables as follows: (i) a Transformation and Quality Strategy, (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 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 create a Transformation and Quality Strategy. The TQS is the 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 1115 Waiver, OAR 410-141-3525, and 42 CFR § 438.330(a) and (b) relating to Quality Assurance and Performance Improvement.

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 and template for Contract Years two through five will be updated by OHA and made available to Contractor no later than October 1 preceding each Contract Year.

(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 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) In accordance with the State 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) Plans for an internal Quality Improvement Committee that develops and operates under an annual quality strategy, a work plan that incorporates implementation of system improvements, and an internal utilization review oversight committee that monitors utilization against practice guidelines and Treatment Planning protocols and policies.

(3) In accordance with federal requirements including those under 42 CFR § 438.330 (a) and (b) related to Quality Assessment and Performance Improvement (QAPI) Program obligations:

(a) Care Coordination for Members with Serious and Persistent Mental Illness;

(b) Contractor's Grievance and Appeal System, inclusive of complaints, Notices of Adverse Benefit Determination, Appeals, and Contested Case Hearings,

(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.

(4) 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

(5) 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 made available to Contractor by October 1 preceding 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 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's TQS Progress Report to determine whether Contractor is making progress toward achieving the objectives and timelines identified in its TQS.

(a) Contractor shall provide its records and all documentation supporting the data and information included in its annual TQS Progress Report to OHA upon request by OHA.

(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 be 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 CFRs and the State 1115 Waiver , OHA will provide Contractor's Contract Administrator with Administrative Notice of such failure and give Contractor the opportunity to demonstrate evidence of progress and compliance before pursuing any of its other rights and remedies under this Contract.

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. Performance Measures

a. As required by Health System Transformation, Contractor shall be accountable for performance on outcomes, quality, and efficiency standards set forth in this Contract. 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 as set forth in this Sec. 3, Ex. B, Part 10.

(1) Contractor's performance, as documented in its Performance Data, shall serve as the basis for determining Contractor's eligibility for financial and non-financial 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) The Metrics and Scoring Committee, organized under ORS 414.638, is responsible for and will revise and adopt measures, benchmarks, and Improvement Targets annually.

(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 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 shall 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) 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 such amendment results in a modification or reduction of Member Enrollment or Contractor's Service Area.

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 and other incentive payments for a Contract Year are subject to the maximum percentage specified by 42 CFR § 438.6(b)(2). 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, unless the Metrics & Scoring Committee approves publication by a later date due to unforeseen circumstances that would impact a specific measure or measures including, but not limited to, effects of the COVID-19 pandemic.

(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 as a Reference Document 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 a designated percentage 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. The designated percentage is anticipated to be at least two percent (2%) except in specific circumstances as identified by OHA or the Legislature. 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, unless otherwise specified in a CCO's contract.

(2) Quality Pool distributions will be based on 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) Contractor shall provide OHA with all information needed to calculate all required EHR, attestation, and hybrid metrics no later than April 1 of the Distribution Year. OHA will provide Contractor with its final claims-based 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. Contractor shall 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 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 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 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 shall offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Providers of Health-Related Services 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 1115 Waiver and 42 CFR § 438.330(d), Contractor shall ongoing create and implement a program of Performance Improvement Projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to improve health outcomes and 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 undertake PIPs that address at least four (4) of the eight (8) focus areas listed below in this Para. b, Sec. 6, Ex. B, Part 10. One of the four shall be the Statewide PIP identified in focus area Sub. Para. (4) below of this Para. b, Sec. 6, 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 three (3) PIPs from the list 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,

(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 Contractor's network, and

(8) Social Determinants of Health and Equity.

c. 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 shall 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. Contractor shall provide OHA, via Administrative Notice, with quarterly status reports for each of its four (4) PIPs. Quarterly status reports are due on April 30, July 31, October 31, and January 31 of each Contract Year. Such quarterly reports shall be made using the PIP progress Report template located at: 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 410-141-3525, convene a Quality Improvement Committee to oversee its TQS and related quality assurance performance improvement efforts. Contractor's Quality Improvement 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 Quality Improvement 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. External Quality Review

a. In conformance with 42 CFR § 438.350 and § 438.358, and 42 CFR § 457.1250**.** Contractor shall permit OHA and its designees to have access to, or provide OHA with, Contractor's Records and facilities, and information requested by OHA and its designees, for the purpose of an annual External Quality Review of Contractor's compliance with all Applicable Laws and this Contract as well as the quality outcomes and timeliness of, and access to, services provided under this Contract.

b. An External Quality Review Organization will perform the annual EQR as determined by OHA. In the event OHA designates an EQRO to perform the EQR, OHA will ensure the EQRO meets the criteria set forth in 42 CFR § 438.354. In addition, OHA will, in accordance with 42 CFR § 438.310 and § 438.350, also do, in connection with the EQR, all of the following:

(1) Implement an EQR protocol that complies with CMS protocols required by 42 CFR § 438.352 and provide such protocols to Contractor, prior to 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 the EQRO to produce a report and information required under 42 CFR § 438.364 and to provide such information to Contractor promptly after completion; and

(4) 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.

c. Consistent with 42 CFR § 438.350, § 438.358, and § 457.1250 the EQRO will:

(1) Perform an EQR in a manner consistent with protocols established by CMS, which shall include, at a minimum, the elements in 42 CFR § 438.358(b).

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

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

(4) Provide technical guidance, or direct the EQRO to provide technical guidance as directed by OHA, to Contractor to assist 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.

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

e. 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. Contractor shall promptly investigate and take action to remedy such adverse clinical situation.

f. Contractor shall provide evidence of resolution of all EQR findings to the EQRO.The EQRO 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.

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Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all the Work to be performed under this Contract, OHA will pay Contractor a monthly CCO Payment for each Member enrolled under the Contract according to OHA records. The monthly CCO Payment Rate authorized for each Member is that amount indicated in Attachment 1 to this Exhibit C, CCO Rates, for each Member's Rate Group. OHA will prorate the CCO Payment for Members who are enrolled or disenrolled mid-month. OHA may withhold Payment for New Members when, and for so long as, OHA 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 reflect a Risk Corridor in accordance with Sec. 6 below of this Ex. C.

c. Contractor shall comply with all applicable payment obligations to ICHPs as set forth in 25 USC § 1621e and 42 CFR § 438.14(b)(2) and (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 Contractor to Hospitals per OAR 410-125-0230 plus an amount to be retained by Contractor to cover the cost of administering managed care taxes. OHA may also send Contractor additional QDPs, which may include an amount to be paid by Contractor to Hospitals or other Providers such as Ground Emergency Medical Transportation (GEMT) Providers. QDPs will be authorized per OAR 410-125-0230 or other applicable OAR governing QDPs as may be amended from time to time. QDPs will be based on OHA's authority under 1115 waivers approved by CMS, which may include but is not limited to one or more waivers relating to the COVID-19 Emergency or as authorized by 42 CFR § 438.6(c). Contractor shall make QDPs to Hospitals or other Providers in the amounts indicated in a monthly report created by OHA to assist Contractor in distributing Quality and Access funds to the appropriate Hospital or other Provider. Contractor shall submit electronic payment to an account established by the Hospital or other Provider within five (5) Business Days after receipt of the monthly report. If an error is identified in the monthly report, 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. As described in OAR 410-141-3565, OHA may require Contractor 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. If Contractor has a contractual relationship with a designated Type A, Type B, or Rural critical access Hospital, Contractor shall provide representations and warranties to OHA that said contract establishes the total reimbursement for the 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 will ensure that no Payment is made to a Provider other than Contractor for services available under the Contract between OHA and Contractor, except when these payments are specifically provided for in Title XIX of the Social Security Act.

3. Changes in Payment Rates

a. The CCO Payment Rates may be changed only by amendment to this Contract pursuant to Sec. 22, Ex. D.

b. In the event CCO Payment Rate adjustments are required by CMS in order to approve this Contract, and such Payment Rates are decreased as a result thereof, OHA shall have the right to recover the difference between amounts paid in excess of the decreased amount required by CMS in accordance with Sec. 7 of Ex. D; however, OHA shall ensure such amounts are recovered in a manner that does not have a material, adverse effect on Contractor's ability to maintain the required minimum amounts of risk-based capital as such minimum amount is set forth in Ex. L of this Contract.

c. 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 of this Contract.

d. 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 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 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 Sec. 22., Ex. D of this Contract.

(d) 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%.

(6) Notwithstanding the foregoing, 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.

e. This 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. If such change increases the CCO Payment owed by OHA to Contractor, then OHA will make a Payment to Contractor, by one-time adjustment to a future regularly scheduled Capitation Payment or by separate Payment. If such change decreases the CCO Payment owed by OHA to Contractor, then any amount paid to Contractor in excess of the decreased amount will be subject to recovery under Para b above of this Sec. 3, Ex. C and Sec. 7, Ex. D and any other applicable provisions of this Contract governing Overpayments.

4. Timing of CCO Payments

a. The date on which OHA will process CCO Payments for Contractor's Members depends on whether the Enrollment occurred during a weekly or monthly Enrollment cycle. OHA will provide a schedule of Enrollment end of month deadlines for each month of the Contract period. On months where the first of the month falls on a Friday, Saturday or Sunday, CCO Payments will be made available to Contractor no later than the eleventh (11^{th}) 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 will be made available to Contractor by the tenth (10^{th}) day of the month to which such Payments are applicable, except for those occurrences each year when the weekly and monthly CCO Payments coincide with each other.

b. Both sets of Payments described in Subsection a of this section 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 that the two transaction files will balance. If Contractor believes that there are any errors in the Enrollment information, Contractor shall provide OHA's Contract Administrator with Administrative Notice of such errors. Contractor may request an adjustment to the Remittance Advice no later than 18months 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 processes the correction(s).

d. OHA will make retroactive CCO Payments to Contractor for newborn Members. Such Payments will be made to Contractor by the tenth (10^{th}) day of the month after OHA adds the newborn(s).

e. Services that are not Covered Services provided to a Member or for any health care services provided to Fee-for-Service Clients are not entitled to be paid as CCO Payments. Fee-for-service claims for Payment must be billed directly to OHA by Contractor, its Subcontractors, or its Participating Providers, all of which must be enrolled with OHA in order to receive Payment. Billing and Payment of all Fee-for-Service claims shall be pursuant to and under OAR Chapter 410, Division 120.

5. Settlement of Accounts

a. If a Member is Disenrolled, any CCO Payments received by Contractor for the period for which the Member was Disenrolled will be considered an Overpayment and will be recouped by OHA under Para. f. below of this Sec. 5, Ex. C.

b. OHA will have no obligation to make any Payments to Contractor for any period(s) during which Contractor is in breach of this Contract, to the 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, 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 limit exceed the amount of Payments to which Contractor was entitled under the amendment, OHA will have the right to recover any such Overpayments.

d. Any Payments received by Contractor from OHA under this Contract, and any other payments received by Contractor from OHA pursuant to any other contract or agreement between Contractor and OHA, or pursuant to any other circumstances that result in a claim by OHA for the recovery of amounts previously paid to Contractor by OHA, or Contractor received funds from any other source, to which Contractor is not entitled under the terms of this Contract, such payments or funds received shall be deemed an Overpayment and OHA will have the right to recover such Overpayment from Contractor in accordance with Sec. 7, Ex. D of this Contract. OHA shall ensure that recovery of Overpayments do not have a material, adverse effect on Contractor's ability to maintain its required, minimum amount of risk-based capital.

e. OHA has the right to recover Sanctions imposed in 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 or Sec. 7 of Ex. D to this Contract.

f. Any Overpayment or recovery amount imposed under Ex. B-Part 9 or Ex. C of this Contract may be recovered by Recoupment from any future payments to which Contractor would otherwise be entitled from OHA (e.g., setoff 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 in dispute and shall not be charged interest on any payments so withheld.

g. OHA will Recoup from Contractor Payments made to Contractor or amounts paid to Providers for sterilizations and hysterectomies performed where Contractor failed to meet the requirements of Ex. B, Part 2, Sec. 6, Para. c. of this Contract. The Recoupment amount 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 forms or certifications. OHA will 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 Ex. B, Part 2, S. 6, P. c of this Contract.

(3) Sterilizations and hysterectomies that Contractor denied for payment shall not be included in the Recoupment calculation, however, they must be reported in the submission. The report of these sterilizations and hysterectomies must be accompanied by a signed statement certifying that Contractor did not make payment for the surgery or any services, which are specifically related to the procedure.

(4) The number of vasectomy, tubal ligation, and hysterectomy procedures that do not meet the documentation requirements of Ex. B, Part 2, S. 6, P. c of this Contract, shall be multiplied by the assigned "value of service."

(5) "Value of service" for vasectomy, tubal ligation, and hysterectomy means the OHP amount calculated by OHA's internal actuarial unit for each category of service using the Encounter Data.

(6) The results of SP (4), of this P. g, S. 5, Ex. C will be totaled to determine the amount of Overpayment made to Contractor for hysterectomies and sterilizations subject to recovery pursuant to Sec. 7, Ex. D, this Contract.

(7) The final results of the review and recovery calculation will be 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.

6. CCO Risk Corridors

Contractor shall comply with the requirements for administration of the Risk Corridors established in this Section. The CCO Risk Corridors utilize specific percentages above and below a target amount, establishing "bands" of risk, which define how Contractor and OHA will review the adjusted costs of the expenses of Members receiving eligible services, subject to settlement.

a. Hepatitis C DAA Settlements.

(1) Completion of Data Submissions. The period from January 1, 2021, through December 31, 2021, 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, 2022. Contractor shall 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) Timely and accurate Encounter Data for all Hepatitis C DAA drugs.

(b) In a form specified by OHA, the following attestations:

i. 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-for-Service Preferred Drug List (also known as the

practitioner managed prescription drug plan). 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 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;

ii. That all Members eligible for, and who received, Hepatitis C DAA drugs followed the same criteria and Prior Authorization protocol as specified in the OHA-approved coverage criteria for FFS 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, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA; and

iii. That Contractor has not received and will not seek conflicting supplemental rebates for Hepatitis C DAA Drugs dispensed during the Hepatitis C Risk Corridor Period. In the same form, Contractor shall also report any Offsets as it relates to Hepatitis C DAA expenses. Contractor may continue to collect supplemental rebates for Hepatitis C DAA Drugs, as long as doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.

(c) Details of the care management protocol for each Member receiving DAA Drugs for treatment of Hepatitis C. OHA will consult with the Coordinated Care Organizations to develop a definition for "adequate care management." The definition is posted on the CCO Contract Forms Website.

(2) OHA will compare the Hepatitis C DAA 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.

(3) Hepatitis C DAA Expenses will be compared with Hepatitis C DAA Revenue.

(4) 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 that Contractor failed to perform adequate care management for Hepatitis C DAA Drugs.

(5) The outcome of this settlement process will be used to determine whether OHA owes a Payment to Contractor or Contractor owes a payment to OHA.

b. Hepatitis C Risk Corridor Payments.

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

(a) When Contractor's Hepatitis C DAA Expenses for the Hepatitis C Risk Corridor Period are equal to or greater than one-hundred five percent (105%) of the Hepatitis C DAA Revenue, OHA will pay Contractor an amount equal to one-hundred

percent (100%) of Hepatitis C DAA Expenses in excess of one-hundred five percent (105%) of the Hepatitis C Revenue.

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

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

(3) OHA will, after conferring with 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 CY21 Rate Certification – CCO Rates"***. The Actuarial Report is available at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.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 methodology in accordance with Ex. B, Part 8, Sec. 9.

9. Quality Pool

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 42 CFR § 438.8 Contractor shall maintain a Minimum Medical Loss Ratio at or above the MMLR Standard for its total Member population and shall 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 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 Forms Website as well as in accordance with CMS Rules 42 CFR § 438.8 Medical Loss Ratio. Provider Stabilization Payments that are included in the numerator of the MLR must:

(1) be reported as incurred claims,

(2) have been available on comparable terms to comparably situated Providers,

(3) not provide more favorable terms to Providers that are Affiliates of Contractor, and

(4) be supported by such details as the Instructions may specify.

d. 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 the Oregon False Claims Act liability, in the manner required by the Minimum Medical Loss Ratio Rebate Calculation Report Instructions.

e. Contractor shall submit its MMLR Rebate Report for each Reporting Period to OHA, via Administrative Notice, each year by August 31 of the year following the Reporting Period based on OHA's instructions and provided template(s).

f. 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 Legal Notice of appeal from Contractor shall include written support for the appeal.

(3) Any appeal shall be conducted as an Administrative Review process will be conducted in the manner described in OAR 410-120-1580(3)-(6). Contractor understands and agrees that Administrative Review is the sole avenue for review of the MMLR Rebate Reports that it has appealed. The decision on 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 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 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.

g. 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 may be Offset against future CCO Payments or otherwise recovered in accordance with Sec. 7, Ex. D of this Contract.

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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, 2021, through December 31, 2021, 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

(CCO Payment Rate documents specific to Contractor are set forth in Attachment 1 to Exhibit C, attached at the end of this Contract)

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Exhibit D – Standard Terms and Conditions

1. Governing Law, Consent to Jurisdiction

This Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding collectively, the "Claim") between OHA or any other agency or department of the State of Oregon, or both, and Contractor that arises from or relates to this Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County or of Multnomah County for the State of Oregon; provided, however, (a) if federal jurisdiction exists then OHA may remove the Claim to federal court, and (b) if a 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 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 Behavioral Health services; (v) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (vi) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (vii) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. OHA's performance under this Contract is conditioned upon Contractor's compliance with the provisions of ORS 279B.220, ORS 279B.225, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).

b. In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Contractor under this Contract to Clients or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. OHA shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall cause all Subcontractors under this Contract to comply with the requirements of this provision.

c. Contractor shall comply with the federal laws as set forth or incorporated, or both, in this Contract and all other federal laws applicable to Contractor's performance under this Contract as they may be adopted, amended or repealed from time to time.

3. Independent Contractor

a. Contractor is not an officer, employee, or Agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

b. If Contractor is currently performing work for the State of Oregon or the federal government, Contractor by signature to this Contract, represents and warrants that Contractor's Work to be performed under this Contract creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Contractor currently performs work would prohibit Contractor's Work under this Contract. If compensation under this Contract is to be charged against federal funds, Contractor certifies that it is not currently employed by the federal government.

c. Contractor is responsible for all federal and State taxes applicable to compensation paid to Contractor under this Contract and, unless Contractor is subject to backup withholding, OHA will not withhold from such compensation any amounts to cover Contractor's federal or State tax obligations. Contractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Contractor under this Contract, except as a self-employed individual.

d. Contractor shall perform all Work as an Independent Contractor. OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, OHA may not and will not Control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work.

4. Representations and Warranties

a. Contractor's Representations and Warranties. Contractor represents and warrants to OHA that:

(1) Contractor has the power and authority to enter into and perform this Contract;

(2) This Contract, when executed and delivered, shall be a valid and binding obligation of Contractor enforceable in accordance with its terms;

(3) Contractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Contractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Contractor's industry, trade or profession;

(4) Contractor shall, at all times during the Term of this Contract, be qualified, professionally competent, and duly licensed to perform the Work; and

(5) Contractor prepared its Application related to this Contract, if any, independently from all other 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. 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 shall 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 Ex. 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 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 unless otherwise mutually agreed. Upon request, Contractor shall provide its taxpayer identification number and other necessary banking information to receive EFT Payment. Contractor shall maintain at its own expense a single financial institution or authorized payment agent capable of receiving and processing EFT using the Automated Clearing House (ACH) transfer method. The most current designation and EFT information will be used for all Payments under this Contract. Contractor shall provide this designation and information on a form provided by OHA. In the event that EFT information changes or Contractor elects to designate a different financial institution for the receipt of any Payment made using EFT procedures, Contractor shall provide the changed information or designation to OHA on an OHA-approved form. OHA is not required to make any Payment under this Contract until receipt of the correct EFT designation and Payment information from Contractor.

7. Recovery of Overpayments or Other Amounts Owed by Contractor

a. **IF PAYMENTS UNDER THIS CONTRACT, OR UNDER ANY OTHER CONTRACT BETWEEN CONTRACTOR AND OHA, RESULT IN PAYMENTS TO CONTRACTOR TO WHICH CONTRACTOR IS NOT ENTITLED (I.E., OVERPAYMENT), OHA SHALL HAVE THE RIGHT TO PURSUE A RECOVERY, FOLLOWING THE ADMINISTRATIVE PROCEDURES SET FORTH BELOW IN PARAGRAPH b OF THIS SECTION 7. FOLLOWING EXHAUSTION OF THE ADMINISTRATIVE PROCEDURES SET FORTH BELOW IN PARAGRAPH b OF THIS SECTION 7, 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.**

b. **OHA WILL PROVIDE CONTRACTOR WITH PRIOR WRITTEN LEGAL NOTICE OF ANY PAYMENTS MADE TO WHICH CONTRACTOR WAS NOT ENTITLED (I.E., OVERPAYMENT MADE UNDER THIS CONTRACT OR ANY OTHER CONTRACT BETWEEN CONTRACTOR AND OHA AS SET FORTH IN**

EXHIBIT C, SECTION 5, PARAGRAPH d, AND WHETHER DISCOVERED BY OHA AS A RESULT OF AN AUDIT, OR OTHERWISE) AND WHICH OHA IS ENTITLED TO RECOVER. IN THE EVENT CONTRACTOR BELIEVES CONTRACTOR WAS RIGHTFULLY ENTITLED TO ALL OR PART OF SUCH PAYMENTS, CONTRACTOR MAY APPEAL THE RECOVERY. IN ORDER TO APPEAL OHA'S INTENDED RECOVERY, CONTRACTOR SHALL FILE WITH OHA AS SPECIFIED IN THE LEGAL NOTICE A WRITTEN OBJECTION WITHIN FOURTEEN (14) DAYS FROM THE RECEIPT OF SUCH 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 OR OTHER SUM IN DISPUTE AND THE MANNER IN WHICH THE OVERPAYMENT OR OTHER SUM 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.

8. Indemnity

a. **GENERAL INDEMNITY. CONTRACTOR SHALL DEFEND, SAVE, HOLD HARMLESS, AND INDEMNIFY THE STATE OF OREGON AND OHA AND THEIR OFFICERS, EMPLOYEES, 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, AGENTS, INSURERS, AND ATTORNEYS (OR ANY COMBINATION OF THEM) UNDER THIS CONTRACT. INDEMNIFIABLE EVENTS INCLUDE, WITHOUT LIMITATION, (i) UNAUTHORIZED DISCLOSURE OF CONFIDENTIAL RECORDS OR PROTECTED INFORMATION, INCLUDING WITHOUT LIMITATION RECORDS AND INFORMATION PROTECTED BY HIPAA OR 42 CFR PART 2, (ii) ANY BREACH OF SEC. 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 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, 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 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. 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.**

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 NEGLIGENCE, WILLFUL, OR INTENTIONAL MISCONDUCT OF CONTRACTOR'S EMPLOYEES, SUBCONTRACTORS, OR AGENTS.

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. THE OBLIGATIONS OF THIS SECTION 8 ARE NOT SUBJECT TO THE LIMITATION ON DAMAGES SET FORTH IN SECTION 12 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 Legal Notice or such longer period as OHA may specify in such 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) Contractor commits any breach 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 or failure is not cured within fourteen (14) days after receipt of OHA's Notice, or such longer period as OHA may specify in such Notice; or

(5) Contractor knowingly has a relationship with a Person described in Sub. Para. (6) below, 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) The prohibited affiliations in Sub. Para. (5) above apply to a Person that:

(a) Is a director, officer, or partner of Contractor;

(b) Is a subcontractor of Contractor;

(c) Has beneficial ownership of 5 percent or more of Contractor's equity; or

(d) Is a network provider or person with an employment, consulting or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Contract.

(7) If OHA determines that health or welfare of Members is in jeopardy if this Contract continues; or

(8) Contractor fails to enter into an amendment described in Sec. 22, Para. b below of this Ex. D**.**, as necessary for the amendment to go into effect on its proposed effective date.

(9) Any notice of default by Contractor shall 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 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 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, 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) Recoupment or Withholding of Overpayments under Sec. 7 above of this Ex. D or 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.

c. Default by OHA. OHA 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 Withholding or Recoupment for Overpayment or other Offset, and OHA fails to cure such

failure within fifteen (15) days after receipt of Contractor's Legal Notice of such failure to pay or such longer period as Contractor may specify in such Legal Notice; or

(2) OHA commits any breach of any covenant, warranty, or obligation under this Contract, and such breach or default is not cured within thirty (30) days after Contractor's Legal Notice or such longer period as Contractor may specify in such Legal Notice.

Any notice of default by Contractor shall identify, with specificity, the term or terms of this Contract allegedly breached.

d. Contractor's Remedies for OHA's Default. In the event OHA is in default under Sec.9, Para. c. above of this Ex. D, terminate Contractor's sole remedy shall be a claim for any unpaid amounts then due and owing from OHA to Contractor, as identified in Exhibit C, net of any Recoupment for Overpayment or other Offset. Except as may be expressly permitted under Sec. 8. Para. 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.

e. Termination

(1) OHA's right to 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) days' prior written Legal Notice of termination by OHA to Contractor; or

(b) Upon receipt of written 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 discretion, to continue to make payments under this Contract; or

(a) Upon receipt of written 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 from the planned funding source; or

(b) Notwithstanding any claim Contractor may have under Section 15, "Force Majeure," upon receipt of written Legal Notice of termination to Contractor if OHA determines that continuation of the Contract poses a threat to the health, safety, or welfare of any Member, including any Medicaid eligible individual, under Contractor's care.

(2) OHA's Right to terminate for Cause. In addition to any other rights and remedies OHA may have under this Contract, and subject to Sec. 9, Para. e, SP (3) below of this Ex. D, OHA will have the right, at its sole discretion and without liability to Contractor, to issue 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 Sec. 9, Para. a, Sub. Para. (1) above of this Ex. D because Contractor 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 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 Sec. 9, Para. a., Sub. Para. (3) above of this Ex. D because Contractor commits any breach of any covenant, warranty, obligation or agreement under this Contract, fails to perform the Work under this Contract within the time specified herein or any extension thereof, or so fails to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms.

(d) Contractor has failed to carry out the substantive terms of its Contract or meet the applicable requirements of 1932, 1903(m) or 1905(t) of the Social Security Act.

(3) Before Terminating this Contract under 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 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. 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. 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, such Administrative Review, subject to any appeal thereof, is deemed to satisfy any requirement for a pre-termination hearing; and

(b) After Administrative Review, give Contractor written 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 has provided Contractor with Legal Notice that it has terminated its Contract under Sec. 9, Para. e., Sub. Para. (1) or intends to terminate this Contract under 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 immediately without cause.

(4) Contractor's Right to terminate for Cause. Contractor may terminate this Contract for cause if OHA is in default under 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 at its Discretion.

(a) No later than one hundred and thirty-four (134) days prior to the end of a Contract Year, other than Contract Year five, at the end of which this Contract will expire, OHA will provide Contractor's Contract Administrator with Administrative Notice of the proposed changes to the terms and conditions of this Contract that will be submitted by OHA to CMS for approval for the next Contract Year. At its sole

discretion, Contractor may terminate this Contract without cause by written Legal Notice to OHA not later than one hundred and twenty (120) days prior to the effective date of any Renewal Contract, for termination effective as of the Renewal effective date. A refusal by Contractor to enter into a Renewal Contract terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D.

(b) If the Oregon Legislature adopts budgetary changes that require OHA to alter the rates under this Contract, OHA will prepare and offer Contractor a required amendment to the rates (the **"Required Rate Amendment"**). No later than one hundred and thirty-four (134) days prior to the effective date of the Required Rate Amendment, OHA will provide Contractor's Contract Administrator with Administrative Notice of the proposed changes to the rates that will be submitted by OHA to CMS for approval. At its sole discretion, Contractor may terminate this Contract without cause by written Legal Notice to OHA not later than one hundred and twenty (120) days prior to the effective date of the Required Rate Amendment, for termination effective as of the effective date of the Required Rate Amendment. A refusal by Contractor to enter into the Required Rate Amendment terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e., Sub. Para. (5) of this Ex. D and has the same effect as the failure to enter into a Renewal Contract.

(6) Notwithstanding Contractor's Legal Notice of termination or failure to enter into a Renewal Contract or the Required Rate Amendment 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 and be amended as proposed by OHA until ninety (90) days after Contractor has, in accordance with the criteria prescribed by OHA, provided a Transition Plan in accordance with Sec. 10, Para. a below of this Ex. D.

(7) OHA may waive compliance with the deadlines in Sub. Paras. (5) and (6) of this Sec. 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 the Required Rate Amendment) or intends to not Renew (or not enter into the Required Rate Amendment), but fails to provide Legal Notice of non-Renewal (or fails to enter into the 2021 Required Rate Amendment) to OHA one hundred and twenty (120) days prior to the date of any Renewal Contract, OHA will have the right to extend this Contract for the period of time OHA considers necessary, in its sole discretion, to accomplish the termination planning described in this Sec. 9, Para. e., Sub. Para (6) of this Ex. D.

(8) After receipt of Contractor's Notification of intent not to Renew (or not to enter into the Required Rate Amendment), or upon an extension of this Contract as described in Sub. Paras. (6) and (7) of this Sec. 9., Para. e. above of this Ex. D, OHA will issue written Notice to Contractor specifying the effective date of termination, Contractor's operational and reporting requirements, and timelines for submission of deliverables.

(9) Mutual termination. This Contract may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

(10) Automatic termination. This Contract will automatically be subject to termination under the condition described in 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 Legal Notice of termination to the other party 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. After providing or receiving Legal Notice of termination, or, in the case of expiration under Section 1.1 of the General Provisions to this Contract, at least one hundred twenty (120) days before the Expiration Date of this Contract, Contractor shall 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 410-141-3710, which includes Contractor drafting and providing to OHA, via Administrative Notice, with a Transition Plan. 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, including, without limitation, operational and reporting requirements, submitting deliverables as required by OHA and OAR 410-141-3710;

(2) Identifying a Transition Coordinator (with contact information) as 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 provide to, and obtain from, OHA approval of a Transition Plan shall give OHA the right to extend the termination date by the amount of time necessary in order for both OHA to approve Contractor's Transition Plan and for Contractor to carry out its obligations under such approved Transition Plan.

c. During the Transition Period Contractor shall be required to provide to OHA status reports every thirty (30) days detailing Contractor's progress in carrying out the Transition Plan. Contractor shall submit a final status Report that describes how Contractor has fulfilled all of its obligations under the Transition Plan including an explanation of how it will resolve 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) Maintain adequate staffing to perform all functions specified in Contract.

(3) Promptly supply all information requested by OHA for reimbursement of any claims outstanding at the time of termination.

(4) Promptly make available any signed Provider agreements requested by OHA.

(5) 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) Forwarding of all records related to Members, including high-needs Care Coordination;

(b) 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 after the Contract termination date;

(c) Identifying chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy;

(d) 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;

(6) 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 Health, Oral Health, and managed Long Term Services and Supports records, patient files, and any other information necessary for the efficient care management of Members as determined by OHA. Such records shall be in a format or formats directed by OHA and shall be provided at no expense to OHA or the Member. 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;

(f) Any other information or records deemed necessary by OHA to facilitate the transition of care.

(g) Arrange for the retention, preservation, and availability of all Records under this Contract, including, but not limited to those Records related to Member Grievance and Appeal records, litigation, base data, Medical Loss Ratio data, financial reports, claims settlement information, as required by Contract, State and federal law.

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

a. 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) OHA need not furnish a Legal Notice or any other type of notice of termination for a termination by expiration;

(2) If OHA offers Contractor a successor contract to be effective immediately upon expiration of this Contract, then OHA will provide Contractor with Legal Notice of the proposed terms and conditions of the Contract, as will be submitted by OHA to CMS for approval,

and within fourteen (14) days of receipt of the CMS approved successor contract, Contractor shall provide OHA with Legal Notice if Contractor does not intend to enter the successor contract. Such Legal Notice will not relieve Contractor of any undertakings Contractor has provided to OHA in the procurement for the successor contract;

(3) 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) Contractor shall perform the actions described in 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. 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) 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 Contractor written release agreeing that all continuing obligations of this Contract have been fulfilled, whichever is earlier.

(2) 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) Assist OHA with Grievances and Appeals for Dates of Service prior to the termination date.

(4) Provide as required in Exhibit L to this Contract the financial reporting deemed necessary by OHA, including but not limited to:

(a) Quarterly and Audited Financial Statements up to the date specified by OHA; and

(b) 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 or Personal Injury Lien units, as applicable.

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's Expiration Date, in order to ensure Members receive continuity of services, do all of the following:

(1) Continue to provide services to Members for the period in which a CCO Payment has been made, including inpatient admissions up until discharge;

(2) Plan and carry out an orderly and reasonable transfer of Member care in progress, whether or not those Members are hospitalized;

(3) Continue to provide timely submission of information, reports and records, including Encounter Data, required to be provided to OHA during the Term of this Contract; and

(4) Continue to make timely payment of Valid Claims for services to Members for dates of service during the Term of this Contract.

d. If Contractor continues to provide services to a Member after the date of termination, OHA is only authorized to pay for services subject to OHA rules on a Fee-for-Service basis 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. Upon termination, OHA will conduct an accounting of both CCO Payments paid or payable and Members enrolled during the month in which termination is effective. Payment will then be calculated and Paid to Contractor as follows:

(1) Mid-Month termination: For a termination of this Contract that occurs during mid-month, the CCO Payments for that month shall be apportioned on a daily basis. Contractor shall be entitled to CCO Payments for the period of time prior to the date of termination and OHA shall be entitled to a refund for the balance of the month.

(2) 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) Notification of Outstanding OHA Claims: Contractor shall promptly provide OHA with Administrative Notice of any outstanding claims for which OHA may owe, or be liable for, a Fee-for-Service payment(s), which are known to Contractor at the time of termination or when such new claims incurred prior to termination are received. In connection with such Administrative Notice, Contractor shall supply OHA with all information necessary for reimbursement of such claims.

(4) Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for services received by Members during the period of this Contract. Contractor is responsible for Submitting financial and other reports required during the period of this Contract to OHA's Contract Administrator via Administrative Notice.

(5) Withholding: Regardless of the reason for termination of this Contract, in the event OHA has not approved Contractor's Transition Plan by sixty (60) days prior to the termination date, OHA will have the right to withhold 20% of Contractor's CCO Payment(s) for the last month this Contract remains in effect and such amount shall be held by OHA, until OHA has given written approval to Contractor's Transition Plan.

f. 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. Limitation of Liabilities

a. **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 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.

13. 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 ORS 414.593, 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, OHA will not make such Reports available to the Public until Contractor has redacted all Protected Information and had an opportunity to redact any Trade Secrets of Contractor or its Subcontractors ("Contractor Trade Secrets"), from such Reports. All Reports subject to posting on OHA's website, or any other easily accessible website as may be directed by OHA, are identified in Exhibit D-Attachment 1. OHA shall provide Contractor with a Guidance Document about the redaction process, including information about the circumstances under which submission of a Redaction Log is required for a redacted Report.

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 Protected Information and, if desired, any Contractor Trade Secrets. Once such Report has been redacted, Contractor shall resubmit such Report to OHA, via Administrative Notice, to the same destination used to submit the initial, unredacted Report to OHA. Contractor shall include with its redacted Report the corresponding Redaction Log, as applicable. Contractor shall use the Redaction Log template located on the CCO Contract Forms Website.

c. If Contractor's Redaction Log identifies one or more redactions that OHA determines does not meet the definition of Protected Information or Trade Secrets or both under this Contract, OHA will provide Contractor's Contract Administrator with Administrative Notice of such determination identifying the redactions that do not constitute Protected Information. 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. Contractor may redact only Contractor Trade Secrets.

d. Contractor is responsible for ensuring that it submits, within the time period described in Para. b above of this Sec. 14, Ex. D a redacted copy of any of its Reports with all Protected Information and, as desired, any Contractor Trade Secrets redacted. Contractor's redacted copy must obscure all Protected Information and such Trade Secrets so that OHA's disclosure of the Report will not disclose Protected Information or Contractor Trade Secrets that Contractor desires to redact. If Contractor does not submit a redacted Report within the twenty (20) day period, OHA will have the right to assume the Report contains no Protected Information and no Contractor Trade Secrets that Contractor desires to redact and will post the unredacted Report as provided to OHA. If Contractor does submit a redacted Report within the twenty (20) day period, OHA shall have the right to assume Contractor's redacted Report is complete and no additional redactions are required to be made prior to OHA posting such Report on the OHA website. OHA shall have no liability

whatsoever to Contractor or any third party for any claims arising out of or related to Contractor's failure to redact, in whole or in part, Protected Information or Trade Secrets from a Report.

15. Access to Records and Facilities; Records Retention; Information Sharing

a. Contractor shall maintain, and require its Subcontractors and Participating Providers to maintain, all financial records relating to this Contract in accordance with best practices or National Association of Insurance Commissioners accounting standards. In addition, Contractor shall maintain any other Records in such a manner as to clearly document Contractor's performance. Contractor acknowledges and agrees that OHA, CMS, the Oregon Secretary of State, DHHS, the Office of the Inspector General, the Comptroller General of the United States, the Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Contractor, 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 is conducted or equipment is used (or both conducted and used).

(1) The right to audit under this section exists for 10 years from, as applicable, the Expiration Date or the date of termination, or from the date of completion of any audit, whichever is later.

(2) 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.

b. Contractor shall retain and keep accessible all Records for the longer of ten years or:

(1) The retention period specified in this Contract for certain kinds of Records;

(2) The period as may be required by Applicable Law, including the records retention schedules set forth in OAR Chapters 410 and 166; or

(3) Until the conclusion of any audit, controversy or litigation arising out of or related to this Contract.

c. In accordance with OAR 410-141-5080, OHA has the right to provide the Oregon Department of Consumer and Business Services with information reported to OHA by Contractor provided that OHA and DCBS have entered into information sharing agreements that govern the disclosure of such information.

16. Information Privacy/Security/Access

If the Work performed under this Contract requires Contractor or, when allowed, its Subcontractor(s) to access or otherwise use any OHA Information Asset or Network and Information System to which security and privacy requirements apply, and OHA grants Contractor, its Subcontractor(s), or both access to such OHA Information Assets or Network and Information Systems, Contractor shall comply and require its Subcontractor(s) to which such access has been granted to comply with the terms and conditions applicable to such access or use, including 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. 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, 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 Legal Notice to Contractor after 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 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 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 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. 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. Assignment of Contract, Successors in Interest

a. Contractor shall not assign or transfer its interest in this Contract, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as OHA may deem necessary, including but not limited to Exhibit B, Part 8, Section 14. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in the Contract.

b. The provisions of this Contract shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

20. Subcontracts

In addition to all of the other provisions OHA 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 under this Contract provisions to ensure that OHA will receive the benefit of Subcontractor performance as if the Subcontractor were Contractor with respect to Sections 1, 2, 3, 4, 15, 16, 19, 20, 25, and 31-33 of this Exhibit D. OHA's consent to any Subcontract shall not relieve Contractor of any of its duties or obligations under this Contract.

21. 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. Amendments

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

(1) Due to changes in federal or State statute or regulations, or due to changes in Covered Services and CCO Payments under ORS 414.735, or if failure to amend this Contract to effectuate those changes 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 reduce or expand the Service Area, or reduce or expand the Enrollment limit, or both, and any CCO Payment Rate change as may be necessary to align with the expansion or reduction thereof and which will be made in accordance with Exhibit C, Sec. 3 of this Contract;

(4) As required by CMS; and

(5) To the extent OHA deems such changes are necessary to obtain CMS approval of this Contract or the CCO Payment Rates.

Except as otherwise permitted by law, OHA will send to Contractor 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 to go into effect on its proposed effective date, is a default of Contractor under Sec.10, Para. a., Sub. Para. (6) of this Ex. D.

c. Any changes in the CCO Payment Rates under ORS 414.735 shall take effect no sooner than sixty (60) days following final legislative action approving the 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. 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. 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. Survival

All rights and obligations cease upon termination or expiration of this Contract, 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 set for the below in this Sec. 24. Without limiting the forgoing or anything else in this Contract, in no event shall Contract expiration or termination 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 4 and 5

c. Exhibit B, Part 10: Section 3

d. Exhibit D: Sections 1, 4 through 13, 15 through 17, 19 through 30, 32.

e. Exhibit. E: Section 6, HIPAA Compliance (but excluding paragraph d) shall survive termination for as a 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. 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 two (2) years unless a longer period is set forth in this Contract:

(1) Claims Data

(a) The submission of all 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 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; and

(d) Adjustments to encounter claims in the event Contractor recovers any 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 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 and 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;

(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;

(b) Reconciliation and right of setoffs;

(c) Recoupment of MMLR Rebates;

(d) Reconciliation of prescription drug rebates;

(e) Recoupment of capitation paid for 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.

(6) Sanctions and Liquidated Damages

(a) Contract expiration or termination does not limit OHA's ability to impose Sanction or Liquidated Damages for the failures or acts (or both) as set out in Exhibit B, Part 9.

(b) The decision to impose a Sanction or Liquidated Damages does not prevent OHA from imposing additional 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 9.

26. Legal Notice; Administrative Notice

Except as expressly provided otherwise in this Contract, notices required under this Contract shall be made in accordance with the terms set forth below in this Sec. 26.

a. "**Legal Notice**" 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 to OHA: To the physical address identified for OHA's Contract Administrator as set forth in Section 2 of the General Provisions of this Contract

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: To the physical address identified for Contractor's Contract Administrator as set forth in Section 2 of the General Provisions of this Contract

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**" shall be deemed duly given and effective only when provided as follows:

(1) If to OHA: In the form and to the destination indicated in Exhibit D-Attachment 1 attached to this Contract between the last page of Exhibit M and Exhibit C-Attachment 1.

(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 or functional equivalent of each Administrative Notice 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 Exhibit D-Attachment 1,

the communication or deliverable shall be made to OHA's Contract Administrator by means of Administrative Notice at the following email address: CCO.MCODeliverableReports@dhsoha.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. In the event Contractor requires additional time to comply with the deadline provided by OHA, Contractor and OHA will negotiate in good faith to identify another deadline. If the Parties cannot agree upon a deadline after forty-eight (48) hours of Contractor's initial request, Contractor shall provide the deliverable to OHA on the date OHA identified in its response to Contractor's initial request.

(2) **If to Contractor:** To the email address for Contractor's Contract Administrator as set forth in Section 2 of the General Provisions of this Contract.

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 b.

c. **If Contract is Silent**. In the event a particular provision in this Contract is silent with respect to the means or method of communication, the communication shall be made to OHA's Contract Administrator by Administrative Notice.

27. 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. Headings and Table of Contents

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

29. 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. Counterparts

This Contract and any subsequent Amendments may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Contract and any Amendments so executed shall constitute an original.

31. 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. 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 OHA. Contractor shall make immediate contact with the OHA office when media contact occurs. The OHA office will assist Contractor with an appropriate follow-up response for the media.

33. 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, 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 (PPACA), (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, is for more than $10,000, then Contractor shall comply and require all Subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. Clean Air, Clean Water, EPA Regulations

If this Contract, including Amendments, exceeds $100,000 then Contractor shall comply and require all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 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, Contractor certifies, to the best of 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, Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. Contractor shall require that the language of the certification made under this Sec. 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. 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 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://sharedsystems.dhsoha.state.or.us/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 OHA EDT Rules, 943-120-0100 through 943-120-0200. In order for Contractor to exchange electronic data transactions with OHA in connection with claims or Encounter Data, eligibility or Enrollment information, authorizations or other electronic transaction, Contractor shall execute an EDT Trading Partner Agreement with OHA and shall comply with the OHA EDT Rules.

d. Consultation and Testing. If Contractor reasonably believes that Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Contractor shall promptly consult the OHA HIPAA

officer. Contractor or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and OHA testing schedule.

7. Resource Conservation and Recovery

Contractor shall comply and require all Subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 U.S.C. 6901 et seq.). Section 6002 of that Act (codified at 42 U.S.C. 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

8. Audits

a. Contractor shall comply, and require all Subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

b. If Contractor expends $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 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 to be a Subcontractor if the Person is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension." (See 2 CFR Part 180). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

Contractor shall ensure that no amounts are paid to a Provider that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

a. The Provider is Controlled by a Sanctioned individual.

b. The Provider has a contractual relationship that provides for the administration, management or provision of Medical Services, or the establishment of policies, or the provision of operational support for the administration, management or provision of Medical Services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act.

c. The Provider employs or contracts, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services, with one of the following:

(1) Any individual or entity excluded from participation in federal health care programs.

(2) Any entity that would provide those services through an excluded individual or entity.

d. The Contract prohibits Contractor from knowingly having a Person with ownership of 5% or more of 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 Contractor unless DHHS directs otherwise; and

(3) Shall have the right not to Renew or extend this Contract with Contractor unless DHHS provides to the State a written statement describing compelling reasons that exist for Renewing or extending 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 services under the Medicaid Act, Title XIX, 42 USC Section 1396 et seq., and CHIP benefits established by Title XXI of the Social Security Act, including without limitation:

a. Keep such Records as are necessary to fully disclose the extent of the services provided to individuals receiving OHP assistance and shall furnish such information to any State or federal agency responsible for administering the OHP program regarding any payments claimed by such Person or institution for providing OHP services as the State or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR § 431.107(b)(1) & (2); and 42 CFR § 457.950(a)(3).

b. Comply with all disclosure requirements of 42 CFR § 1002.3(a); 42 CFR § 455 Subpart (B); and 42 CFR § 457.900(a)(2).

c. Certify when submitting any claim for the provision of OHP services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the claim will be from federal and State funds and that any falsification or concealment of a material fact may be prosecuted under federal and State laws.

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

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 shall 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 shall 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. Contractor shall inform Members that complaints concerning noncompliance with the Advance Directive requirements may be filed with OHA.

Contractor is prohibited from conditioning the provision of care or otherwise discriminating against a Member based on whether or not the individual has executed an Advance Directive per 42 CFR § 438.3(j); 42 CFR § 422.128; or 42 CFR § 489.102(a)(3).

15. Practitioner Incentive Plans

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 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 by CMS under 42 CFR 438.730, Payments provided for under this Contract will be denied for Members who enroll after the imposition of the Sanction, as set forth under 42 CFR 438.726.

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 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 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 Subcontractors. These policies and procedures shall include, at a minimum, safeguards:

(1) against Contractor's disclosure of Applications, bids, proposal information, or source selection information; and

(2) requiring Contractor to:

(a) promptly report, but in no event seven (7) Business Days after impermissible contact, any contact with a Contractor, bidder, or offeror in writing, via Administrative Notice, to OHA's Contract Administrator; and

(b) reject the any offer or proposed offer of employment; or disqualify itself from further personal and substantial participation in the procurement if Contractor contacts or is contacted by a Person who is a contractor, bidder, or offeror in a procurement involving federal funds regarding possible employment for Contractor.

a. 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 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 Predecessor CCO Contract or other similar contract between Contractor and OHA.

(2) Contractor shall apply the definitions in the State Public Ethics Law, ORS 244.020, for "actual conflict of interest," "potential conflict of interest," "relative," and "Member of household."

(3) "Contractor" for purposes of this section includes all Contractor's Affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common Control with 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).

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 reporting requirements and 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 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.

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 shall 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 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 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 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 shall 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 Members (whether or not the benefits are furnished by Contractor);

e. If a 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 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 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 for medical/surgical benefits in the same classification.

23. Effect of Loss of Program Authority

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the State paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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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 who work under this Contract in the State of Oregon shall comply with ORS 656.017 and provide the required Workers´ Compensation coverage, unless such employers are exempt under ORS 656.126. Contractor shall ensure that each of its Subcontractors complies with these requirements.

2. **Professional Liability:** Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this Contract, Professional Liability insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this contract by the Contractor and Contractor's Subcontractors, agents, officers and employees in an amount of not less than $2,000,000 per occurrence, incident or claim. Annual aggregate limit shall not be less than $4,000,000. If coverage is on a claims made basis, then either an extended reporting period of not less than 24 months shall be included in the Professional Liability insurance coverage, or the Contractor shall maintain either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the effective date of this Contract, for a minimum of 24 months following the later of (i) Contractor's completion and OHA's acceptance of all Services required under this Contract, or, (ii) OHA or Contractor termination of contract, or, (iii) the expiration of all warranty periods provided under this Contract.

3. **Commercial General Liability:** Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this Contract, Commercial General Liability insurance covering bodily injury and property damage in a form and with coverages that are satisfactory to OHA. This insurance shall include personal and advertising injury liability, products and completed operations and contractual liability coverage for the indemnity provided under this contract. Coverage shall be written on an occurrence basis in an amount not less than $1,000,000 per occurrence. Annual aggregate limit shall not be less than $2,000,000.

4. **Automobile Liability:** Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this contract, Automobile Liability insurance covering Contractor's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in combination with the commercial general liability insurance (with separate limits for commercial general liability and automobile liability).

5. **Network Security and Privacy Liability:** Contractor shall provide network security and privacy liability insurance for the duration of the Contract and for the period of time in which Contractor (or its Business Associates or Subcontractor(s)) maintains, possesses, stores or has access to OHA or client data, whichever is longer, with a combined single limit per claim or incident of no less than the limit provided in the table below that corresponds to Contractor's average monthly Member Enrollment. This insurance shall include coverage for third party claims and for losses, thefts, unauthorized disclosures, access or use of OHA or client data (which may include, but is not limited to, Personally Identifiable Information ("PII"), Payment Card Data and Protected Health Information ("PHI")) in any format, including coverage for accidental loss, theft, unauthorized disclosure access or use of OHA data.

Contractor's Average Monthly Member Enrollment	Minimum Combined Single Limit per Claim or Incident
1 to 49,000	$1,000,000
49,001 to 74,000	$2,000,000
74,001 to 149,000	$3,000,000
149,001 to 249,000	$4,000,000
249,001 to 349,000	$5,000,000
349,001 to 449,000	$6,000,000

6. **Excess/Umbrella Insurance:** A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance.

7. **Additional Insured:** The Commercial General Liability Insurance and Automobile Liability insurance required under this Contract shall include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to Contractor's activities to be performed under this Contract. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

8. **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.

9. **Proof of Insurance:** Contractor shall provide to OHA information requested in Section 5, "Contractor Data and Certification" of the General Provisions of this Contract, 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.

10. **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 9 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.

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

1. Delivery System Network Provider Monitoring and Reporting Overview

a. Contractor shall 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 410-141-3515 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, Behavioral 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, Contractor may be required to contract with Providers located outside of the defined Service Area.

c. Contractor shall Monitor, document, report and evaluate its Provider Network as set forth in this Ex. G.

d. Contractor's obligations under Para. c, above of this Ex. G, shall include the development of a system and methodology for Monitoring and evaluating Member access including, but not limited to, the availability of Network Providers within time and distance standards, adherence to standards for wait time to appointment for primary care, specialty care, and Behavioral Health services, and sufficiency of language services and physical accessibility.

e. Contractor shall promptly and fully remedy any Provider Network deficiencies identified through the course of self-assessment, or as a result of OHA Monitoring, or EQRO review.

f. The accuracy of data submitted in the DSN Provider Report will be periodically validated against available sources. If data for more than ten percent (10%) of Providers is incorrect for individual data elements, OHA shall have the right to require Contractor to correct 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. If any activities have been Subcontracted, Contractor shall also describe its oversight and Monitoring procedures to ensure compliance with the requirements of this Contract.

2. Delivery System Network Provider Monitoring and Reporting Requirements

a. Contractor shall provide OHA with a quarterly DSN Provider Capacity Report no later than thirty (30) days following the end of each calendar quarter. Contractor shall provide OHA with an annual DSN Narrative Report by July 31 of each Contract Year for the 12-month period ending on the immediately preceding June 30. In addition, Contractor shall update such Reports any time there has been a change in Contractor's Provider Network, including termination of a Provider or upon expiration of a Provider agreement, and at OHA request. Contractor shall utilize the DSN Provider Capacity and Narrative Report templates located on the CCO Contract Forms Website. Contractor shall provide the Reports to OHA via Administrative Notice.

(1) All of Contractor's Participating Providers must be included in the DSN Provider Capacity Report. Notwithstanding the foregoing, in order to include a Provider and contracted

facilities in its quarterly DSN Provider Capacity Report, 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 Capacity Report shall be categorized by Provider Taxonomy Code.

(3) For PCPCHs, information should include the certification Tier and the number of Members assigned to the contracted 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, including Qualified and Certified Health Care Interpreters, 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 410-141-3515 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 annual DSN Narrative Report descriptions of all of the following:

(1) How Contractor identifies and incorporates the needs of linguistically and culturally diverse populations within its Community;

(2) Processes used to develop, maintain and Monitor an appropriate 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 Member, Provider, and staff feedback about the 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 access issues by geographic area, by Provider type, by special needs populations, and by Subcontractor or Subcontracted activity;

(5) How Contractor utilizes data provided by OHA (as such data is required to be provided under OAR 410-141-3525) and from Contractor's relevant reports on workforce capacity and diversity to inform Contractor's workforce development strategies;

(6) Strategies Contractor will undertake to work with local communities, local and State educational resources, and other OHA resources, including financial incentives, 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 and Linguistically Appropriate and Trauma Informed;

(7) Evidence that either (i) the number of Indian Health Care Providers that are Participating Providers is sufficient to ensure timely access to Covered Services for those AI/AN enrolled with Contractor who are eligible to receive services from such Providers: or (ii) no or very few Indian Health Care Providers are offering services or otherwise located within Contractor's Service Area;

(8) Identified training needs of Contractor's Provider Network and how Contractor will address such needs to improve the ability of the Provider Network to deliver Covered Services to Members;

(9) If Contractor is unable to provide any necessary Covered Services which are Culturally and Linguistically and Medically Appropriate to a particular Member within its Provider Network, how Contractor will adequately and timely cover these services out of network for the Member, for as long as Contractor is unable to provide such services. Non-Participating Providers must coordinate with Contractor with respect to payment;

(10) The names of any and all Providers terminated from 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

(11) An evaluation of the prior year's DSN Narrative Report and a description of how previously identified issues have been corrected.

d. Contractor shall also include in the annual DSN Narrative Report a description of current barriers to network adequacy, gaps in Contractor's 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.

e. Contractor shall include in the annual DSN Narrative Report information and analysis of how it establishes, ensures, Monitors and evaluates adequate Provider capacity, including the geographic location of network Providers and Members, considering distance, travel time, and the means of Transportation ordinarily used by Members.

3. 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 provide it to OHA, via Administrative Notice, by July 1 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.

Name of publicly funded program	Type of public program [*(e.g., county mental health dept.)*]	County in which program provides services	Does Contractor have a Memorandum of Understanding? [*Description of the services provided in relation to Contractor's services*]	What has been the involvement of the public program in Contractor's operations (on the board, on the Community Advisory Council, on Quality Assurance Committee, specify if Subcontract, etc.)?
	Local Mental Health Authority			
	Community Mental Health Programs			
	Type B AAA			
	State APD district offices			
	Local public health authority			

4. 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, via Administrative Notice, by July 1st of every year. 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.

(1) Referral and cooperative arrangements with culturally diverse social and support services organizations, as required under the applicable provisions of Exhibit B, Part 4 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 of this Contract.

(3) Cooperative arrangements and agreements with DHS Child Welfare offices to assure timely Assessments for Member children placed under Child Welfare custody, as required by Exhibit B, Part 2 of this Contract).

5. Hospital Network Adequacy

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

b. OHA will review and analyze non-contracted claims by Contractor annually to determine if all Hospital services are adequately represented.

(1) OHA will use following benchmarks to evaluate and assess the adequacy of Contractor's Hospital network:

(a) A minimum of 90% of Contractor's total inpatient admissions (excluding all Outpatient services) shall be provided in Hospitals under contract with Contractor.

(b) A minimum of 90% of Contractor's total dollars paid for all Outpatient services (excluding amounts paid for inpatient admissions) shall be provided in Hospitals under contract with Contractor.

(2) In those instances where the percentage of Non-Contracted Hospital services are below the benchmarks or OHA's review of Contractor's annual Hospital admissions by Diagnosis Related Groups indicates Contractor's Hospital network is not adequate, OHA will determine if Contractor and the 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 be based on the following criteria:

(a) The amount of time Contractor has been actively trying to negotiate a contractual arrangement with the Hospital(s) for the services involved;

(b) The payment rates and methodology Contractor has offered to the Hospital(s);

(c) The payment rates and methodology the Hospital has offered to Contractor;

(d) Other Hospital cost associated with non-financial contractual terms Contractor has proposed including prior-authorization and other utilization management policies and practices;

(e) Contractor's track record with respect to claims payment timeliness, overturned claims, denials, and Hospital complaints;

(f) Contractor's solvency status; and

(g) The Hospital(s)' reasons for not contracting with Contractor.

(3) If OHA determines that Contractor has made a good faith effort to contract with the Hospital, OHA will modify the Benchmark calculation, if necessary, for Contractor to exclude the Hospital so the Contractor is not penalized for a Hospital's failure to contract in good faith with Contractor.

(4) If OHA determines that Contractor did not make a good faith effort to negotiate and enter into reasonable contracts, OHA will have the right to require Contractor to provide a monthly Hospital Adequacy Report and to pursue all of its rights and remedies under this Contract until such breach is remedied.

Exhibit H – Value Based Payment

Contractor shall demonstrate, as specified below, how it will use Value-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, 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 Contract Effective Date, Contractor shall make at least twenty percent (20%) of its projected annual payments to its Providers in contracts that include a VBP component as defined by the Health Care Payment Learning and Action Network's ("LAN") "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 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 that are not Carve-Out 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, Contractor shall use the VBP Roadmap for Coordinated Care Organizations and the OHA VBP Technical Guide for Coordinated Care Organizations for the VBP specifications and the appropriate LAN VBP category for each payment model. 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. 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 care, maternity care, children's health care, Behavioral Health care, and Oral Health care. The term "expanded from an existing contract" includes, but is not limited to, an expansion of Contractor's existing contracts such that more Providers or Members, or both Members and Providers, are included in the arrangement, 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). Contractor will use the VBP Technical Guide for Coordinated Care Organizations for the care delivery area VBP specifications

b. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher throughout the Term of this Contract. Contractor shall implement care delivery area VBPs for a minimum of 12 months, according to the following schedule:

(1) In 2021, Contractor shall develop three (3) new or expanded VBPs. The three (3) new or expanded VBPs shall be in Hospital care, maternity care, and Behavioral Health care. A VBP may encompass two care delivery areas; e.g., a Hospital maternity care VBP that met specifications for both care delivery areas could count for both Hospital care and maternity care delivery areas;

(2) Commencing on January 1, 2022, Contractor shall implement the three (3) new or expanded VBPs that were developed during Contract Year two (2021) under Sub. Para. (1) above of this Para. b, Sec. 2, Ex. H;

(3) Commencing on January 1, 2023, Contractor shall implement a new VBP in one additional care delivery area;

(4) Commencing on January 1, 2024, Contractor shall implement one final new VBP in the remaining care delivery areas; and

(5) By the end of 2024, Contractor should have implemented 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-per-month payments to its PCPCH clinics as a supplement to any other payments made to PCPCHs, be they Fee-for-Service or VBPs. Contractor shall also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPM payments must be in amounts that are material and increase each of the five 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) level, as defined by the LAN Framework. Unless combined with a LAN Category 2C VBP or higher, such payment arrangements shall not count toward Contractor's annual CCO VBP minimum threshold or Contractor's annual VPB targets.

4. VBP Targets by Year

a. Contractor shall increase the level of VBPs each Contract Year during the Term of 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 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 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 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 Contractor's payments to Providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards Contractor's annual VBP targets.

(4) For services provided in 2024, no less than seventy percent (70%) of the CCO's payments to 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 Contractor's payments to Providers must also fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. These payments will apply towards Contractor's annual VBP targets.

5. VBP Data Reporting; Overview

Contractor shall use the LAN categories and OHA VBP Technical Guide for Coordinated Care Organizations to accurately report and submit its VBP data. In addition, technical specifications are

required as set forth below in Sections 6 through 9 below of this Exhibit H. Contractor shall implement the VBP plan Contractor submitted 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 has the right to require Contractor to provide detailed information on the size of the VBPs made pursuant to the terms and conditions of this Contract for the purposes of ensuring that Contractor is implementing meaningful levels of incentives, such that Providers are being encouraged and rewarded for improving overall quality performance. Contractor shall use the CCO VBP Reporting Measures form to describe the specific quality metrics used in Contractor's VBP arrangements for Contract Year two (2021) and shall submit the form to OHA, via Administrative Notice, by the first Friday in October of Contract Year two; this retrospective submission is an accommodation in recognition of the effects of the COVID-19 Emergency. Commencing in Contract Year two, Contractor shall submit this form annually to OHA, via Administrative Notice, by the first Friday in October to describe the specific quality metrics to be used in its VBP arrangements for the upcoming Contract Year. The VBP Reporting Measures form is located on the following website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.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) If Contractor determines that the HPQMC Aligned Measures Menu, or if and when developed, the HPQMC Core Measure Set, do not include appropriate metric(s) for planned VBPs, or the measures are not aligned, Contractor may request approval from OHA to use other metrics defined by the National Quality Forum or similar national measure steward. If Contractor proposes an original metric Contractor shall provide, promptly upon request of OHA, additional information that supports Contractor's request to use its original metric to OHA as requested.

(a) Such requests shall be made to OHA, via Administrative Notice, using the VPB Reporting Measures form and submitted by the due date for each Contract Year as specified in Para. a, Sec. 5 of this Ex. H.

(b) Such requests must be accompanied by Contractor's rational for proposing different metrics or measures, measure specifications, and applicable details outlined in the VBP Reporting Measures Form. Such requests will be approved by OHA provided that the rational for Contractor's proposed metrics or measures (or both) are both related, do not overly burden the delivery system, and are designed to advance the Triple Aim goals of improving quality of care, health care outcomes for Members, and lowering costs.

b. In the event OHA contracts with one or more CCOs serving Members in the same Service Area Contractor and such other CCO(s) shall participate in OHA-facilitated discussions to select Performance Measures and any other areas of alignment that Contractor and such CCO(s) shall be required to incorporate into their respective VBP Provider contracts for the common Provider types and specialties. OHA will inform Contractor, via Administrative Notice to Contractor's Contract Administrator, of the Provider types and specialties that will be subject to the process previously described. Upon conclusion of such discussions, OHA shall notify Contractor, via Administrative Notice to Contractor's Contract Administrator, which Performance Measures and any other areas

of alignment Contractor and the other CCO(s) must incorporate into their applicable 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

Contractor's VBP data reporting obligations for Contract Years two (2021) through five (2024) shall include all of the following:

a. By May 6 of each Contract Year, Contractor shall submit to OHA, via Administrative Notice, the PCPCH VBP data and Care Delivery Area VBP data template. The template must be submitted in Excel format. The template is posted on OHA's VBP webpage at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx. The reporting template includes summary data stratified by LAN categories that describes Contractor's payment arrangements implemented in the required care delivery areas as well as the required payment made to PCPCHs.

b. In June of each Contract Year, Contractor must engage in interviews with OHA to:

(1) Describe the activities regarding the VBP arrangements during the previous Contract Year;

(2) Discuss the outcome of 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 implementation plans for the care delivery areas that will be implemented in the upcoming Contract Year; and

(4) Any additional information requested by OHA on VBP development and implementation.

c. By September 30 of each Contract Year, Contractor shall submit VBP data via APAC's Payment Arrangement File and Payment Arrangement Control File for the previous Contract Year. Additional information about this reporting obligation is provided in the APAC Reporting Guide located at: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx. OHA will 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 VBP targets.

d. Contractor's VBP data reporting obligations for Contract Years four (2023) and five (2024) shall survive termination of this Contract. Contractor shall submit to OHA the VBP data for Contract Years four and five by February 15 of calendar years 2025 and 2026, respectively. Such data shall be submitted to OHA in accordance with Para. c of this Sec. 6, Ex. H.

7. Transparency and VBP Data

OHA will publish Contractor's VBP data, such as the actual VBP percent of spending and LAN category, as well as data pertaining to Contractor's care delivery areas, PCPCH payments, and other information pertaining to VBPs. Notwithstanding the foregoing, OHA will not publish specific payments amounts

made by a Contractor to a specific 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.

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Exhibit I – Grievance and Appeal System

Contractor's Grievance and Appeal System shall consist of the processes Contractor follow with respect to Grievances, Adverse Benefit Determinations, Appeals of Adverse Benefit Determinations, resolutions of Appeals, and access to Contested Case Hearing, as well as the processes to collect and track information about these processes, in accordance with OAR 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860, 42 CFR § 438.400 through § 438.424, this Exhibit I, and any other applicable provisions of this Contract. 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. Contractor's Grievance and Appeal System shall be included in all of Contractor's Member Handbooks, all of its Provider Handbooks, and on Contractor's websites as set forth in this Exhibit I below. 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

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 for Members; and

(2) Require that Members complete the Appeals process with Contractor prior to requesting a 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 other 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 Subcontractors, including its Provider Network, with all Grievance and Appeal requirements in accordance with Applicable Law and the applicable provisions of this Contract.

c. **Filing Requirements.** Contractor's Grievance and Appeal System must provide that Members shall have the right to:

(1) File an Appeal with Contractor.

(2) File a Grievance with OHA or Contractor. If a Member files a Grievance with OHA, OHA will promptly send the Grievance to Contractor to address in accordance with Contractor's Grievance and Appeal System.

(3) Request a Contested Case Hearing with OHA after receiving notice that an Appeal to Contractor has been upheld, except where Contractor fails to adhere to the notice or timing requirements in 42 CFR § 438.408, in which case Member is deemed to have exhausted Contractor's Grievance and Appeals System process and the Member may request a Contested Case Hearing.

d. Timing. Contractor's Grievance and Appeal System must provide that Members shall have the right to:

(1) File a Grievance at any time for any matter other than an Adverse Benefit Determination.

(2) File an Appeal within sixty (60) days from the date on the NOABD.

(3) 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 is upheld, or the date that OHA deems that the Member has exhausted Contractor's Appeals process.

e. General System Requirements

(1) Contractor's Grievance and Appeal System and all communications with Members related thereto shall comply with all of the accessibility requirements set forth in Sec. 4, Paras. c-h and Sec. 5 of Ex. B, Part 3 of this Contract.

(2) Contractor shall permit Members to file a Grievance orally or in writing at Member's option.

(3) Contractor shall permit Members to file an Appeal orally or in writing, consistent with the requirements in OAR 410-141-3890.

(4) Contractor shall treat an oral request for Appeal of an Adverse Benefit Determination as an Appeal and shall establish the filing date as the date of the oral request.

(5) Contractor shall provide, in accordance with 42 CFR § 438.406, Members with all reasonable assistance in completing forms and taking other procedural steps in connection with Grievances, Appeals, and Contested Case Hearings. This assistance 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 free of charge to each Member.

(6) Contractor shall not discourage any Member from using any aspect of the Grievance and Appeal System. Nor shall Contractor:

(a) Encourage any Member to withdraw a Grievance, Appeal, or Contested Case Hearing request already filed;

(b) Use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a Member or as a basis for requesting Member Disenrollment, or

(c) Take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal.

(7) Contractor shall make Grievance and Appeal forms, including those listed in OAR 410-141-3890, available and accessible to Members in all administrative offices.

(8) Individuals who make decisions on Grievances and Appeals must be individuals who:

(a) Were not involved in any previous level of review or decision-making with respect to the Grievance or Appeal;

(b) Were not a subordinate of an individual involved in any previous level of review or decision-making with respect to the Grievance or Appeal; and

(c) Have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease when deciding any of the following:

i. An Appeal of a denial that is based on lack of medical necessity;

ii. A Grievance regarding denial of expedited resolution of an Appeal; or

iii. A Grievance or Appeal that involves clinical issues.

(9) Contractor's Appeal process shall take into account all comments, documents, records, and other information submitted by Member without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

(10) If Contractor Delegates part of the Grievance process to a Subcontractor or Participating Provider, Contractor shall, with respect to any part of the process Delegated:

(a) Validate that performance of the Subcontractor or Participating Provider meets the requirements of this Contract, OAR 410-141-3835 through 410-141-3915, and 42 CFR 438.400 through 438.424;

(b) Monitor the Subcontractor's or Participating Provider's performance on an ongoing basis;

(c) Perform a formal compliance review of the Subcontractor or Participating Provider at least annually to assess performance, deficiencies, and areas for improvement;

(d) Cause the Subcontractor or Participating Provider to take Corrective Action for any identified areas of deficiencies that need improvement; and

(e) Include data collected by Subcontractors or Participating Providers in Contractor's analysis of Grievance system provided to OHA, and ensure data is reviewed by Contractor's Compliance Committee, consistent with contractual requirements for CCO Quality Improvement.

(11) Contractor shall not Delegate to a Subcontractor or Participating Provider the Adjudication of an Appeal, in accordance with OAR 410-141-3875.

2. 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 all of the following:

a. Upon receipt of a Grievance, Contractor shall comply with Grievance process and timing requirements in OAR 410-141-3875, 410-141-3880 and 42 CFR 438.408 as well as 42 CFR § 438.406.

b. Contractor's notice of Grievance resolution shall comply with format requirements and readability standards in OAR 410-141-3585 and 42 CFR § 438.10.

c. Upon receipt of a Grievance from a Member who is in the process of transitioning or transferring from Contractor's plan to a Receiving CCO, as such term is defined in OAR 410-141-3850, and such Grievance relates to such Member's entitlement of continuing benefits "in the same manner and same amount" during the transition of transfer Contractor shall record the Grievance and work with the Receiving CCO to ensure Continuity of Care during the transition.

d. Contractor shall promptly cooperate and cause its Subcontractor to promptly cooperate with any investigations and resolution of a Grievance by either or both DHS' Client Services Unit and

OHA's Ombudsperson as expeditiously as the affected Member's health condition requires, and within timeframes set forth in or required by this Contract.

e. Contractor shall conduct analysis of its Grievances in the context of Quality Improvement activity, consistent with OAR 410-141-3875 and incorporate the analysis into the quarterly data provided to OHA under this Contract.

f. Contractor shall resolve each Grievance and provide notice to the Member of the disposition as expeditiously as the Member's health condition requires within the following timeframes and meeting the following requirements:

(1) **Resolution for Grievances**. Contractor shall provide written notice to the Member, within five (5) Business Days from the date of 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 decision is; or

(b) Contractor's decision will not exceed thirty (30) calendar days from the date of Contractor's receipt of the Grievance, and the reason additional time is necessary.

(2) **Grievance Resolution Notice Requirements**

(a) Contractor may respond orally but shall also, in all instances, respond to all Member Grievances in writing with a notice of Grievance resolution.

(b) Contractor's notice of Grievance resolution shall address each aspect of the Member's Grievance and explain the reason for Contractor's decision.

(c) The language in Contractor's notice of Grievance resolution shall be sufficiently clear that a layperson could understand the disposition of the Grievance.

(d) The notice of Grievance resolution shall also advise all affected Members that they have the right to present their Grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by telephone. Such telephone numbers shall be included in the notice of Grievance Resolution and are as follows:

i. For CSU: 800-273-0557, and

ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450.

3. Notice of Adverse Benefit Determination – Requirements

When Contractor has made, or intends to make, an Adverse Benefit Determination Contractor shall notify the requesting Provider and mail to the Member a written Notice of Adverse Benefit Determination.

a. Contractor's NOABD must comply with all of the following requirements:

(1) Meet the language and format requirements in Secs. 4 and 5 of Ex. B, Part 3 of this Contract and be consistent with the requirements of OAR 410-141-3580, 410-141-3585 and 42 CFR § 438.10, including, without limitation, translating a NOABD for those Members who speak prevalent non-English languages.

(2) Include all of the following information:

(a) Language clarifying that oral interpretation is available for all languages and how to access it;

(b) Date of the notice;

(c) Contractor name, address and phone number;

(d) Name of the Member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health professional, as applicable;

(e) Member's name, address and ID number;

(f) Description and explanation of the service(s) requested or previously provided and an explanation of the Adverse Benefit Determination that Contractor made or intends to make, including whether Contractor is denying, terminating, suspending, or reducing a service or denying a payment for a service in whole or in part;

(g) Date of the service or date service was requested by the Provider or Member;

(h) Name of the Provider who performed or requested the service;

(i) Effective date of the Adverse Benefit Determination if different from the date of the NOABD;

(j) Other conditions Contractor considered 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 1115(a) Waiver;

(k) Clear and thorough explanation for the specific reasons for the Adverse Benefit Determination;

(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 NOABD;

(m) The Member's right or, if the Member provides written consent as required under OAR 410-141-3890(1), the Provider's right to file an Appeal of Contractor's Adverse Benefit Determination with Contractor, including information on exhausting Contractor's one level of Appeal, and the procedures to exercise that right;

(n) The Member's or the Provider's right to request a Contested Case Hearing with OHA only after Contractor's Notice of Appeal Resolution or where Contractor failed to meet Appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

(m) The Member's right to file an Appeal, and the procedures to exercise that right;

(n) The Member's right to request a Contested Case Hearing, and the procedures to exercise that right;

(o) The circumstances under which an expedited Appeal resolution and an expedited Contested Case hearing are available and how to request;

(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;

(q) The Member's right to 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

(r) Copies of the appropriate forms as listed in OAR 410-141-3885.

b. Contractor shall, for every NOABD, meet the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Covered Services:

(a) The NOABD shall be mailed at least ten (10) days before the date of the Adverse Benefit Determination, except as permitted under Ex. I, Sec. 3, Para. b, Sub. Para. (1) (b) and (c).

(b) The NOABD may be mailed less than ten (10) days prior to, but in no event later than, the date the Adverse Benefit Determination takes effect if:

i. Contractor has factual information confirming the death of the Member;

ii. Contractor receives a clear, written statement signed by the Member that the Member no longer wishes services or gives information that requires termination or reduction of services and indicates that the Member understands that termination or reduction of services will be the result of supplying the information;

iii. Contractor can verify the Member has been admitted to an institution where the Member is ineligible for Covered Services from Contractor;

iv. The Member's whereabouts are unknown and Contractor receives a notice from the post office indicating no forwarding address and OHA has no other address;

v. Contractor verifies another state, territory, or commonwealth has accepted the Member for Medicaid services;

vi. The Member's PCP, PCD, or Behavioral Health professional prescribed a change in the level of health services;

vii. There is an Adverse Benefit Determination made with regard to the preadmission screening requirements for LTPC admissions; or

viii. For 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.

(c) The NOABD shall be mailed not less than five (5) days before the date of the Adverse Benefit Determination when Contractor has facts indicating that an Adverse Benefit Determination should be taken because of probable Fraud on the part of the Member, and, Contractor has verified those facts, if possible, through secondary sources.

(2) For denial of payment, the NOABD shall be mailed at the time of any 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 NOABD shall be mailed as expeditiously as the Member's health condition requires and in all cases not later than fourteen (14) calendar days following receipt of the request for service, except that:

i. Contractor may have an extension of up to fourteen (14) additional days if the Member or the Provider requests the extension or when Contractor can justify that a need for additional information and how the extension is in the Member's interest; Contractor shall 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. If Contractor extends the timeframe, in accordance with SSP **(i)** above of this Ex. I, Sec. 3, Para. b, Sub. Para.(3) (a), 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. 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.

(4) For all covered Outpatient Drug authorization decisions, Contractor shall provide a response as described in OAR 410-141-3835.

(5) 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 additional information is needed and that the extension is in the Member's interest. Contractor shall provide its justification for any request to OHA, via Administrative Notice, upon request.

ii. If Contractor extends the timeframe, in accordance with SSP (i) above of this Ex. I, Sec. 3, Para. b, Sub. Para. (3) (a), 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. 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.

(6) A NOABD for a Prior Authorization decision not reached within the appropriate timeframes shall be mailed on the date that the timeframe expires.

4. Handling of Appeals

Contractor shall have written policies and procedures for Contractor's Grievance and Appeal System that meet the requirements of OAR 410-141-3875, 410-141-3890, 410-141-3895, and 42 CFR § 438.406, and address how Contractor will accept, process, and respond to Appeals.

a. Policies and Procedures Required.

In addition to the requirements set forth in Ex. I, Sec. 1, and OAR 410-141-3875, 410-141-3890 and 410-141-3895, Contractor's Grievance and Appeal System shall also include policies and procedures to:

(1) Acknowledge receipt of all Member Appeals as follows:

(a) For non-expedited Appeals: in writing within five (5) Business Days of receipt, and

(b) For all expedited Appeals: orally and in writing within one (1) Business Day of receipt.

(2) Require Members to submit a written Appeal after filing an Appeal orally, unless the Member requests an expedited resolution as provided by OAR 410-141-3890.

(3) Provide Members with a reasonable opportunity to present evidence and make legal and factual arguments in Person as well as in writing as provided by OAR 410-141-3245 3875 Contractor shall inform the Member of the amount of time available to present evidence and argument sufficiently in advance of the resolution timeframe for Appeals as specified in 42 CFR § 438.408(b) and (c).

(4) Provide Appeal information to Members in accordance with Exhibit B, Part 3, Information Materials and Education of Members and Potential Members, and, at a minimum provide Members with the following information:

(a) The sixty (60) days' time limit for filing an Appeal;

(b) The toll-free numbers that the Member can use to file 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 Contested Case Hearing; and

(f) The right to have an attorney or Member Representative present at the Contested Case Hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711.

(5) Include as parties to the Appeal:

(a) The Member and the Representative;

(b) A Provider acting on behalf of a Member, with written consent from the Member;

(c) Contractor; and

(d) The legal Representative of a deceased Member's estate.

(6) Contractor shall document and maintain a record of each Appeal as described in OAR 410-141-3875 and OAR 410-141-3915.

b. Appeal Resolution and Notification

(1) General Requirements for Resolution

(a) Contractor shall resolve each Appeal, and provide notice to Members, as expeditiously as their health condition requires and within the timeframes in this Ex. I, Sec. 4.

(b) If Contractor fails to adhere to the notice and timing requirements in 42 CFR § 438.408, Contractor shall consider the affected Member to have exhausted the Appeals process and allowed to initiate a Contested Case Hearing.

(2) Standard Resolution for Appeals

(a) Contractor shall resolve standard Appeals as expeditiously as a Member's health condition requires and no later than sixteen (16) days from the day Contractor receives the Appeal. Contractor may extend this timeframe by up to fourteen (14) days if:

i. The Member requests the extension; or

ii. Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the affected Member's interest.

(b) If Contractor extends the timeframes, it shall, for any extension not requested by a 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 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) Members may file an expedited Appeal either orally or in writing. For cases in which a Provider indicates, or 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, Contractor shall make an expedited decision.

(b) Contractor shall resolve expedited Appeals as expeditiously as a Member's health condition requires and no later than seventy-two (72) hours from when Contractor received the request for an expedited Appeal.

(c) Contractor may extend the timeframe by up to fourteen (14) days if:

i. The Member requests the extension; or

ii. 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 affected Member's interest.

(d) If Contractor extends the timeframes, it shall, for any extension not requested by a Member, give such Member a written notice of the reason for the delay. Such written notice shall be made within two (2) days of Contractor's decision to extend the timeframe and shall also make reasonable effort to give the Member oral notice of the extension of time. Affected Members have the right to file a Grievance if they disagree with the extension. Contractor shall resolve all such Appeals no later than the expiration date of the extension.

(e) If Contractor denies a request for an expedited Appeal, Contractor shall:

i. Transfer the Appeal to the timeframe for standard resolution. Contractor shall resolve the Appeal no later than sixteen (16) days from the day

Contractor receives the Appeal with possible fourteen (14) day extension in accordance with OAR 410-141-3895; and

ii. Make reasonable efforts to give the affected 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 such Member to file a Grievance with Contractor if they disagree with that decision.

(f) If Contractor approves a request for expedited Appeal but denies the services or items requested in the expedited Appeal, Contractor shall:

i. Inform such Members of their right to request an expedited Contested Case Hearing and send such Members a Notice of Appeal Resolution, Hearing Request and Information forms as outlined in OAR 410-141-3875 and OAR 410-141-3890.

(4) Notice of Resolution of Appeals

Contractor's Notice of Appeal Resolution shall be in a format approved by OHA and written in language that, at a minimum, 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 Notice of Appeal Resolution shall contain, as appropriate, the same elements as the Notice of Adverse Benefit Determination, as specified in OAR 410-141-3885, in addition to:

(a) The results of the resolution process and the date Contractor completed the resolution;

(b) For Appeals not resolved wholly in favor of the Member:

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.

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 Contractor's Notice of Appeal Resolution and how to do so, which includes sending the Notice of Hearing Rights (DMAP 3030) available at https://sharedsystems.dhsoha.state.or.us/forms/ and the Hearing Request Form (MSC 0443) or Appeal and Hearing Request (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx.

iii. The right to continue to receive benefits pending a Contested Case Hearing and how to do so;

iv. Information explaining that if 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 410-141-3900 and OAR 410-141-3905.

(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 OHA 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 141-410-3890.

5. Contested Case Hearings

Contractor's Grievance and Appeal System shall provide Contractor's Members access to a Contested Case Hearing before OHA. Members must complete Contractor's Appeal process prior to receiving a hearing with OHA. In any case where a Contractor fails to adhere to the notice or timing requirements set forth in OAR 410-141-3875 through 410-141-3895, the Member is deemed to have exhausted the Contractor Appeals process and may initiate a Contested Case Hearing. If a Participating Provider filed an appeal on behalf of Member as permitted by OAR 410-141-3890, the Participating Provider must be allowed to request a Contested Case Hearing on behalf of Member. Contractor shall also, in accordance with 42 CFR § 438.406(a), provide all reasonable assistance to Members in completing forms and taking other procedural steps related to the Contested Case Hearing process. Contractor's Grievance and Appeal System must provide for the following:

a. Upon receipt of a request for a Contested Case Hearing, Contractor shall date stamp the hearing request with the date of receipt and immediately transmit the request to OHA with a copy of Contractor's Notice of Appeal Resolution.

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.

c. Contractor shall submit the required documentation described in OAR 410-141-3900, 410-141-3905, and OAR 410-141-3875 to the OHA Hearings unit within two (2) Business Days of Member's request for a Contested Case Hearing.

d. 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 who believes that taking the time for a standard resolution of a Contested Case Hearing could seriously jeopardize the Member's life, health, or ability to attain, maintain or regain maximum function may request an expedited Contested Case Hearing, as described in OAR 410-141-3905.

6. Continuation of Benefits

a. A 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 or Contested Case

Hearing is pending. As used in 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 NOABD; or

(2) The intended effective date of the Action proposed in the NOABD.

b. Contractor shall continue the Member's benefits if:

(1) The Member or Member's Representative timely files the Appeal or Contested Case Hearing request;

(2) The Appeal or Contested Case Hearing request involves the termination, suspension, or reduction of previously authorized services;

(3) 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 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 § 438.420(c) the benefits must be continued until one of the following occurs:

(a) The Member withdraws the Appeal; or

(b) The Contractor issues an Appeal Resolution.

(2) Continuation of benefits pending Contested Case Hearing resolution

If, at the Member's request, Contractor continues or reinstates the Member's benefits while the Contested Case Hearing is pending, pursuant to 42 CFR § 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 Contractor mails the Notice of Appeal Resolution letter

(b) The Member withdraws their Request for Contested Case Hearing; or

(c) A final Contested Case Hearing decision adverse to the Member is issued.

d. Member responsibilities for services furnished while the Appeal or Contested Case hearing is pending

If the final resolution of the Appeal or Contested Case Hearing upholds Contractor's Adverse Benefit Determination, Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal or hearing was pending 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 Contract.

7. Implementation of Reversed Appeal Resolution

a. Services not furnished while an Appeal is pending

If Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal or Contested Case Hearing was pending, 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 Contractor receives the decision reversing the Adverse Benefit Determination.

b. Services furnished while an Appeal is pending

If Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the disputed services were furnished while the Appeal or Contested Case Hearing was pending, Contractor shall pay for the services.

8. Final Order on Contested Case Hearings

OHA will resolve a Contested Case Hearing ordinarily within ninety (90) days from the date Contractor receives the Member's request for Appeal. This does not include the number of days the Member took to subsequently file a Contested Case hearing request. The final order is the final decision of OHA.

9. Record Keeping and Quality Improvement

a. Contractor shall document and maintain a record of all Member Grievances and Appeals in accordance with OAR 410-141-3890, OAR 410-141-3915, OAR 410-141-3875, and 42 CFR § 438.416. Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA Monitoring and oversight.

b. Contractor shall maintain record, in a central location accessible to OHA and available upon request to CMS, for each Grievance and Appeal. The records shall include, at a minimum:

(1) A general description of the reason for the Appeal or Grievance and the supporting reasoning for its resolution;

(2) The Members name and ID;

(3) The date Contractor received the Grievance or Appeal filed by the Member, Subcontractor, or Provider;

(4) The NOABD;

(5) If filed in writing, the Appeal or Grievance;

(6) If filed orally, documentation that the Grievance or Appeal was received orally;

(7) Records of the review or investigation at each level of the Appeal, Grievance, or Contested Case Hearing;

(8) Notice of resolution of the Grievance or Appeal, including dates of resolution at each level;

(9) Copies of correspondence with the Member and all evidence, testimony, or additional documentation provided by the Member, the Member's Representative, or the Member's Provider as part of the Grievance, Appeal, or Contested Case Hearing process; and

(10) All written decisions and copies of all correspondence with all parties to the Grievance, Appeal, or Contested Case Hearing.

10. OHA Review and Approval of Grievance and Appeal System, Policies and Procedures, and Member Notice Templates

a. The 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 System 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 shall 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 shall 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 will notify Contractor within the same thirty (30) day period if additional time is needed for review. 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 shall 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 after the end of each calendar quarter, Contractor shall provide to OHA, via Administrative Notice, the following documentation (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 on the CCO Contract Forms Website;

(2) Samples of NOABD and corresponding Prior Authorization documentation. Contractor's Prior Authorization template shall include, at a minimum: date of the request for the service, the diagnosis codes, including but not limited to medical, dental, behavioral, and transportation billing codes, submitted, the CPT or HCPCS (treatment) codes being requested, and any comorbid diagnosis codes that the 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 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 NOABDs for Applied Behavioral Analysis and Hepatitis C for the previous calendar quarter; and

(4) Any other related documentation requested by OHA.

c. Within forty-five (45) days after the end of each calendar quarter, Contractor shall provide its Grievance System Report to OHA via Administrative Notice. Such Grievance System Report shall be in a format provided by OHA which is available on the CCO Contracts Forms Website. Contractor shall use data collected from its own and its Subcontractors' Monitoring of Contractor's Grievance and Appeal System, including the Grievance and Appeal data reported by Contractor and Subcontractors in their Grievance and Appeal logs to analyze such system. Contractor shall demonstrate how Contractor uses the data it has collected for itself and its Subcontractors to maintain an effective process for Monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Members.

d. Contractor shall promptly comply with all Grievance and Appeal records requests from OHA, CMS, EQRO, and any of their designees. Contractor shall submit, in accordance with such request, records to OHA's Contract Administrator, no later than fourteen (14) days following Contractor's receipt of a request, except where a request is related to a Contested Case Hearing, in which case Contractor shall submit required documentation within twenty-four (24) hours for an expedited hearing and two (2) days for a non-expedited hearing. Contractor is responsible for collecting and submitting the Grievance and Appeal records maintained in part or in full by Subcontractors. Contractor shall revise Grievance and Appeal Systems or Guidebooks (or both), within thirty (30) days of notification by CMS, OHA, 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 shall 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 the Grievance and Appeal Systems of Contractor and its Subcontractors, on a monthly basis, and provide the results of such review to OHA, federal, state, and OHA contracted auditors upon request.

f. If Contractor has Delegated, in part or in full, Monitoring of any Grievance and Appeal System to a Subcontractors or Participating Providers, Contractor shall submit records of such Monitoring to OHA, federal, state, and OHA contracted auditors, upon request. Such Subcontractor or Participating Provider records shall provide evidence of compliance, as required under 42 CFR § 438.230, with provisions in this Contract under OAR 410-141-3835 through 410-141-3915, 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 or Participating Provider Monitoring, up to and including termination of Subcontractor or Participating Provider. Contractor shall submit all records requested under Ex. I, Sec. 10, Para. f. of this Contract to OHA, via Administrative Notice, no later than fourteen (14) days following receipt of the request or in a timeframe established by the requesting entity.

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Exhibit J – Health Information Technology

1. Health Information Technology Requirements

a. Contractor shall maintain a Health Information System that: i) meets the requirements of this Contract; ii) meets the requirements of 42 CFR § 438.242 and section 1903(r)(1)(F) of PPACA; and iii) collects, analyzes, integrates and 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;

(4) Evidence that the Member has been informed of rights and responsibilities;

(5) Grievance, Appeal and 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 system or other documentation system; and

(9) Member demographics such that such information collected includes, at a minimum, those characteristics required to be collected under Sec. 6 of Ex. K to this Contract.

(10) Those Provider characteristics required to be collected under Exhibit G to this Contract;

(11) Member Enrollment; and

(12) Services provided to Members for pharmacy services,

(13) All data required to be reported in connection with Encounter Data reporting.

b. Contractor shall ensure claims data received from Providers, either directly or through a third party submitter, is accurate, truthful and complete in accordance with OARs 410-120-1280, 410-141-3565, and 410-141-3570 by:

(1) Verifying accuracy and timeliness of reported data;

(2) Screening data for completeness, logic and consistency;

(3) Submitting the certification identified in Exhibit B, Part 8;

(4) Collecting service information in standardized formats in accordance with OHA Electronic Data Transmission procedures in OAR Chapter 943 Division 120;

(5) Identifies any fees payable by Members, if any, as required under Member 42 CFR § 438.10; and

(6) Contractor shall provide to OHA, upon request, verification that 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 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 Contractor's claims payment system, request verification of, at a minimum, all of the following:

i. The services furnished;

ii. The name of the Provider furnishing the services;

iii. The date on which the services were furnished; and

iv. The amount of the payment made by the Member, if any, for the services.

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

c. In accordance with 42 CFR § 438.242, Contractor shall make all collected and reported data available upon request to OHA or its designees, or both OHA and its designees.

2. Health Information Technology Roadmap

a. Contractor shall draft and maintain an OHA-approved HIT Roadmap. The HIT Roadmap must contain the information identified in the RFA, and include its plans setting forth all of the activities, milestones, and timelines required to be carried out under the HIT Roadmap as set forth below of this Para. (a) of this Sec. 2, Ex. J and achieve compliance with OAR 410-141-3520. Contractor shall also include in its HIT Roadmap descriptions of how it 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:

(1) Describe how Contractor will facilitate EHR adoption and use for its Provider Network, including physical, Behavioral, and oral Health Providers.

(2) 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. Contractor shall 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) Serve, if elected, on the HIT Commons governance board or one of its committees.

c. Contractor's designated representative shall participate in OHA's HIT Advisory Group (HITAG), at least once annually.

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 that it:

(a) Has an active, signed HIT Commons MOU.

(b) Adheres to the terms of the HIT Commons MOU.

(c) Has paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.

(d) Served, if elected, on the HIT Commons governance board or one of its committees.

(e) Participated in OHA's HITAG, at least once during the previous Contract year.

(2) Identify the EHR(s) vendor/product in use by each of its contracted physical, Behavioral, and Oral Health Providers.

(3) Describe the progress made towards meeting EHR adoption targets, including, without limitation, the proportion of physical, behavioral and 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) Identify the tool(s) used by each of its physical, Behavioral, and Oral Health Providers for Hospital event notifications;

(6) Describe theprogress 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) 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) Report on how Contractor used HIT to support Providers so they can effectively participate in VBP arrangements, including details regarding:

(a) How Contractor provided Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangements applicable to the contracted Providers;

(b) How Contractor provided Providers with VBP arrangements with accurate and consistent information on patient attribution;

(c) How Contractor identified, for Providers with VBP arrangements, (or provided contracted Providers with VBP arrangements with the information needed for those 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 Providers to support Providers' participation in VBP arrangements, including data on risk stratification and Member characteristics that can inform the targeting of interventions to improve outcomes; and

(e) The percentage of Providers with VBP arrangements at the start of the year who had access to these above data.

(10) Contractor shall report on how it used HIT for population health management, including:

(a) Details relating to Contractor's capability to risk stratify and identify and report on Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes; and

(b) For Contract Years two through five (2021-2024), Contractor shall report on provision of risk stratification and Member characteristics to contracted 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 Sub Paras. (1)-(9) above of this Para. d, Sec. 2, Ex. J. OHA 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.

3. Interoperability and Access to Health Information

a. Contractor shall comply with the newly amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule. The provisions of the CMS Interoperability and Patient Access Final Rule, with which Contractor is required to comply are: 42 CFR § 438.242(b)(5)-(6), 42 CFR § 457.1233(d), 42 CFR § 438.62(b)(1)(vi) & (vii). These rules include requirements relating to the: (i) use of application programming interfaces (APIs) to: (y) provide patient access to payer claims, encounter information, and costs, and (z) make managed care plans' provider directories publicly available; and (ii) exchange of certain patient clinical data between payers.

b. Contractor shall review the ONC 21st Century Cures Act Final Rule to determine its obligation to comply with the final rule. Specifically, Contractor shall review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) which are defined in 45 CFR § 171.102, and the exceptions to information blocking as amended by Section 4004 of the Cures Act and as found in 42 USC § 300jj-52, in relation to their contractual and financial relationships. Contractor shall notify OHA, via Administrative Notice, no later than January 31, 2021, whether Contractor meets the definition for an HIE/HIN as it pertains to information blocking.

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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 414.575, 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 (where such representatives are employees of the county) 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. 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 ninety (90) days of the CAC seat becoming open.

c. Contractor shall 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.

d. 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.

e. Notwithstanding the deadline set forth in Para. b above of this Sec. 2, Ex. K, in the event Contractor has not previously entered into a Predecessor Contract with OHA, or this Contract requires Contractor to provide services in Service Area not previously served by Contractor under a Predecessor Contract, Contractor may request from OHA an extension of time of up to three months to complete its initial selection of CAC members.

f. In the event a Member who serves on Contractor's CAC as a 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.

g. Notwithstanding Para. b and f above of this Sec. 2, Ex. K, in the event Contractor is unable, despite its good faith efforts, to replace a CAC member who resigns, is asked to resign, or is otherwise unable to serve on the CAC, within the required ninety (90) day deadline, or the six month deadline in the instance of a Consumer Representative, Contractor may request from OHA an extension of one additional month to complete its replacement of the open CAC seat(s). OHA shall have the right to request, and Contractor shall be required to provide, documentation or other information related to Contractor's efforts to fill an empty CAC seat to assist in making its determination about whether to grant Contractor's request for a one-month extension. 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 Contractor and the CAC;

(3) Provide written reports on the activities of Contractor;

(4) Provide the opportunity for the public to provide written or oral comments; and

b. Contractor shall post on its website contact information for, at a minimum,

(1) The CAC Chairperson; and

(2) A Member of the CAC or Contractor's CAC Coordinator.

c. The CAC shall:

(1) Meet no less than once every three months.

(2) 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 Area(s) informed of the CAC's activities, on other websites. The CAC, 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 414.575(2) and as set forth in this Contract. Such duties include, without limitation, all of the following:

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

(2) Fulfilling the Contractor-determined role for the SHARE Initiative spending as set forth in OAR 410-141-3735.

(3) Fulfilling the Contractor-determined role for the CAC in Community Benefit Initiatives, which are required to be undertaken in accordance with OAR 410-141-3845 and as set forth in Sec. 9 below of this Ex. K.

(4) Overseeing Contractor's development and drafting of Community Health Assessment;

(5) 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 the health needs of all of the Members residing in the Communities within Contractor's Service Area(s); and

(6) Publishing an Annual CHP Progress Report.

5. Contractor's Annual CAC Demographic Report

a. To understand how 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 the Communities within Contractor's Service Areas;

(3) The data sources relied upon by Contractor to report its CAC membership and the demographics of the Communities within Contractor's Service Area;

(4) Whether and how Contractor's total CAC 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) Barriers to and challenges in meeting or increasing alignment between CAC membership and the demographics of the Communities within Contractor's Service Area. In the event the CAC membership does not align with the demographics of the Communities within Contractor's Service Area(s) Contractor shall include an explanation for the lack of alignment;

(6) 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 Communities within Contractor's Service Area; and

(7) Contractor's organizational chart. The organizational chart shall indicate:

(a) The number of persons and the names of the persons who sit on Contractor's 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, Affiliates of Contractor, or Affiliates of Contractor's Subcontractors (or any combination or all of them);

(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)-(7) of this Para. a, Sec. 5, Ex. K, compare in relation to, as applicable, the Tribes or tribal advisory committee in Contractor's Service Area.

b. Contractor shall also submit a graphic that illustrates the same information. Contractor shall submit its graphic illustration 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, no later than June 30 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's CAC shall oversee, with the Collaborative CHA/CHP Partners, the development of the shared Community Health Assessment (CHA) in accordance with OAR 410-141-3730 and in compliance with ORS 414.575. The purpose of a CHA is to assess the health status and needs of, not just Contractor's Members, but the entire 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 shall 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 shall 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 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. Tribal Liaison

viii. Traditional Health Workers,

ix. Culturally specific organizations, including Regional Health Equity Coalitions, and

x. 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, with 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-E indicators across the four key SDOH-E 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) Include 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 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 Contract with OHA prior to entering into this Contract, Contractor shall 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 CHA, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.

h. In the event Contractor has drafted a CHA on or before the Contract Effective Date and such CHA, even if previously approved by OHA: (i) is not representative of Contractor's Service Area, or (ii) has not been updated, as required under OAR 410-141-3730, within the previous five years, Contractor shall 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.

i. 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.

j. Contractor shall promptly make its CHA widely available to the public after OHA's confirmation of receipt of CHA.

k. Pursuant to OAR 410-141-3730, Contractor shall update its CHA every five years; however, nothing in this Contract precludes Contractor updating the CHA 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 414.575, ORS 414.578, and OAR 410-141-3730. 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 shall 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, Tribal Liaison, and 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 and include, without limitation:

(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;

(2) The priorities and goals of the CHP;

(3) A plan and strategies for improving the integration of all services provided to meet the needs of children, adolescents, and families;

(4) A 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;

(5) 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;

(6) 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;

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 its impacts on individuals, 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 shall also develop, with the input of school nurses, school mental health Providers, and as identified in ORS 414.578 (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. 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. If Contractor was not a party to a Predecessor Contract with OHA prior to entering into this Contract, 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. Upon completion and submission to OHA, Contractor shall post its CHP on its website.

k. In the event Contractor has been performing the activities, tasks, services identified in a CHP adopted by its CAC on or before the Contract Effective Date and such CHP: (i) is not representative of Contractor's Service Area, or (ii) has not been updated, as required under OAR 410-141-3730, within the previous five years, Contractor shall 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.

l. In the event OHA determines Contractor's then-current CHP no longer serves its intended purpose, OHA has the right, pursuant to OAR 41-141-3730, to require Contractor to update its CHP in less than five (5) years.

m. Contractor shall provide an Annual CHP Progress Report to OHA on an 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) Identification of 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: SDOH-E Partners and SHARE Initiative

a. Within thirty (30) days after a SDOH-E Partner Subcontract or MOU has been executed by both Contractor and the SDOH-E Partner, Contractor shall submit to OHA, via Administrative Notice, a completed, updated Subcontractor and Delegated Work Report located on the CCO Contracts Forms Website.

(1) Contractor's Subcontract or MOU for its SDOH-E Partners must comply with all of the terms and conditions set forth in Sec. 11, Ex. B, Part 4 of this Contract.

b. **Supporting Health for All through Reinvestment Initiative.** 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 410-141-3735, CCO financial solvency regulations in OAR 410-141-5000 *et seq*, ORS 414.572, and this Contract, on services designed to address health disparities and the SDOH-E.

(1) For all Contract Years, expenditures made under the SHARE Initiative must meet all requirements as specified in the applicable OARs and in this Contract, including without limitation:

(a) SHARE Initiative spending priorities selected by Contractor based on:

i. Contractor's most recent Community Health Improvement Plan that is shared with the Collaborative CHA/CHP Partners, as defined in 410-141-3730, 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 Contractor's Service Area, including local public health authorities, Hospitals, and other CCOs;

ii. 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 identified by OHA; and

iii. Alignment with Contractor's Transformation and Quality Strategy.

(b) A portion of SHARE Initiative expenditures must go directly to SDOH-E Partner(s) for the delivery of services or programs, policy, or systems change, or any of these, related to SDOH-E as agreed to by Contractor. Contractor shall enter into a contract, or MOU as applicable, with each SDOH-E Partner that defines the services to be provided and data collection methods as provided in program Guidance Documents posted on the CCO Contract Forms Website.

(c) Contractor shall designate a role for the CAC in relation to the SHARE Initiative, as described in OAR 410-141-3735.

(2) 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 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 Contractor's CHP as described in OAR 410-141-3730 and 410-141-3735, including the Statewide priority of housing-related services and supports, including Supported Housing;

(b) How the SHARE Initiative Spending 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.;

(c) Identification of the SDOH-E Partner(s), with demonstrated experience delivering services or programs, or supporting policy and systems change, or both, related to SDOH-E, that will receive a portion of SHARE Initiative funding;

(d) A description of how SDOH-E Partners were selected for SHARE Initiative project(s) or initiative(s);

(e) Any ownership, business, or financial relationship between SDOH-E Partners and Contractor, related to SHARE Initiative spending, including a completed Subcontractor and Delegated Work Report;

(f) 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

(g) A description of the CAC's role in the proposed projects or initiatives (or both).

(3) 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.

(4) Contractor shall provide, as requested by OHA from time to time and at least annually, a SHARE Spending Report that shall include narratives and financial reporting of SHARE related obligations and expenditures. The SHARE Spending Report shall identify obligations and expenditures related to the SHARE Initiative (as such Initiative is described in this Ex. K). Guidance documents and templates for the SHARE Spending Report are posted on the CCO Contract Forms Website.

(5) 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 each year's 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.

(6) 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 410-141-3845 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's Community-Benefit Initiative spending shall promote alignment with its then-current CHP.

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 141-410-3845 and OAR 141-410-3500, 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 1.

(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 notify Contractor within thirty (30) days from submission of the approval status of its Health-Related Service Policies; OHA will notify Contractor within the same period if additional time is needed for review. 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

Contractor shall 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's Health Equity Plan shall include the elements identified in this Sec. 10 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 a Health Equity (HE) 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 OHA with an annual update to its Health Equity Plan which was originally submitted in Contract Year one (2020), no later than June 30 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 shall include strategies, objectives, activities, policies and related documentation as requested by OHA such that the foregoing will demonstrate, in compliance with this Contract and Applicable Law, 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 or use of an alternative community engagement process as described in the Health Equity Plan Guidance Document located on the CCO Contract Forms Website;

(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), or use of an alternative community engagement process, 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 or use of an alternative community engagement process, 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), 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) Commencing with the first updated Health Equity Plan submitted in Contract Year two (2021), each Contract Year Contractor shall develop new, or updated existing, strategies 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 expand or otherwise modify the focus areas listed below. Each focus area must have at least one strategy in the Health Equity Plan for each Contract Year. Accordingly, Contractor shall 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 (i) for the utilization of REAL+D data to advance Health Equity (ii) for assessing gaps in the current demographic data systems and processes (both Contractor's and Contractor's Provider Network); (iii) identifying the challenges encountered in collecting demographic data (both Contractor's and Contractor's Provider Network), and (iv) for developing actionable plans for the collection, analysis and reporting of demographic data to meet both federal and state reporting requirements, and facilitate the analysis of the demographic data within the Communities of Contractor's Service Area in order to identify and address SDOH-E disparities;

(c) Providing: (i) effective, equitable, understandable, and respectful quality care and services, including, without limitation, free-of-charge Certified or Qualified Interpreters for spoken and sign languages, to all Members, and (ii) accessible health and healthcare services for individuals with disabilities in accordance with Title III of the 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, 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) and that its Provider Network and Provider Network staff are provided with access to the same;

(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 Health Care 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 training offerings (and any Cultural Competence and implicit bias training Contractor may offer to its Provider Network) 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 Health Care 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, including Certified and Qualified Health Care 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 Contractors employees.

(6) Contractor shall also require all of Contractor's Provider Network and Provider Network staff to attend Cultural Responsiveness and implicit bias training. Such trainings must comply with the requirements set forth in this Para. d, Ex. K of this Contract. Contractor shall also require its Provider Network to comply with all of the reporting requirements set forth in this Para. d, Ex. K; however, such reporting shall be made to Contractor and Contractor will, in turn, incorporate its Provider Network reporting, as required under Sub. Paras. (7)-(9) of this Para. d, Sec. 10, Ex. K, into Contractor's reports in such a manner that will enable OHA to identify Contractor's and its Provider Network's compliance with this Para. d, Sec. 10, Ex. K.

(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 shall 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) Commencing with the Health Equity Plan submitted in Contract Year two (2021), Contractor shall provide, on an annual basis, written documentation to OHA of the Cultural Responsiveness and other related education and training that it will provide to its employees, and that its Provider Network and Provider Network staff will be required to attend (regardless of whether the Provider Network and Provider Network staff will attend Contractor's trainings or attend trainings independent of Contractor) during the Contract Year to which the Health Equity Plan applies.

(a) The documentation shall include a timeline for: (i) providing all required education and training activities, goals and objectives for its employees, and (ii) requiring its Provider Network and Provider Network staff to attend Cultural Responsiveness and other related education and training.

(b) Such documentation shall also include evidence of Contractor's adoption of the criteria and core competencies set forth in this Para. d, Sec. 10, Ex. K and that the adoption of such criteria and core competencies has also been adopted by its Provider Network.

(c) The documentation required under this Sub. Para. 8, Para. d., Sec. 10, Ex. K shall be provided to OHA with the Annual Training and Education Report described in Sub. Para. 9 below of this Para. d, Section 10.

(9) As part of its Health Equity Plan submission, Contractor shall also provide OHA with an Annual Training and Education Report that documents all of the previous Contract Year's training activities that were provided to its employees, 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. The plan shall include trainings required under Sub. Paras. (1) through (6) above of this Para. d, Section 10, Contractor shall provide its Annual Training and Education Report to OHA, via Administrative Notice, on June 30 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 employee 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 for its employees, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract.

e. Annual Health Equity Assessment Report

(1) Contractor shall provide OHA with an Annual Health Equity Assessment Report, via Administrative Notice, on June 30 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 Assessment 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 the Assessment Report on Contract Year one (2020) due in Contract Year two (2021), the Report shall include a description of Contractor's implementation efforts. If Contractor utilized an alternative community engagement process in Contract Year one due to the COVID-19 Emergency, the Report shall describe how Contractor utilized the alternative process, including:

i. Identification of the specific instances where the community engagement requirement was not met and description of the mitigation strategies used;

ii. Utilization of the CAC and, if applicable, an *ad hoc* committee if such as committee was established solely as a proxy for community engagement; and

iii. Description of the formation of the *ad hoc* committee, as applicable, and description of the process by which the CAC and, as applicable, the *ad hoc* committee informed the development of the Health Equity Plan as a proxy

for the community engagement requirement and approved the Health Equity Plan.

(2) For reporting on Contract Years two through five, Contractor's Annual Health Equity Assessment 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 provided to Contractor's employees 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 June 30 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 OHA-4690-19. 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, based on OHA's and THW Commission guidelines, a THW Payment Grid , informed by the recommendations of the THW Commission's Payment Model Committee, that is sustainable. Contractor shall 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/Information-for-Health-Systems,-Providers,-and-THW%27s.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/Information-for-Health-Systems,-Providers,-and-THW%27s.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. Contractor shall draft and maintain a job description for the THW Liaison which shall include responsibility for serving as the single 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) Integrating THWs into the delivery of services;

(2) Addressing barriers to integration and utilization of THWs and their services;

(3) Coordinating Contractor's THW workforce;

(4) 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;

(5) Provide technical assistance to help THWs become enrolled as Provider with Contractor;

(6) Assist and coach Members in utilizing Contractor's THW Providers and services;

(7) Provide assistance and support for establishing THW payments and rates;

(8) Member access to, and utilization of, THWs in both in clinical and community based settings; and

(9) 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:

(1) Provide OHA with its THW Liaison job description for review and approval as set forth below in Para. f of this Sec. 11, Ex. K;

(2) Include in its Member Handbook the benefits and availability of THW services;

(3) Provide the name and contact information for its THW Liaison either in its Member Handbook, in a prominent location on its website referred to in its Member Handbook, or both;

(4) Provide Administrative Notice to OHA with ten (10) days of any change in either its THW Liaison's name, contact information, or both;

(5) 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; and

(6) Communicate in writing with Participating Providers about the availability, scope of practice, and the type of THW services.

f. Contractors must update its THW Integration and Utilization Plan annually. The updated THW Integration and Utilization Plan for the upcoming Contract Year must be submitted to OHA, via Administrative Notice, for review and approval by no later than November 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.

g. 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 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/Information-for-Health-Systems,-Providers,-and-THW%27s.aspx. The data collected and documented in the THW Integration and Utilization Report for each Contract Year shall be provided to OHA by no later than November 15 of each Contract Year, along with Contractor's updated THW Integration and Utilization Plan. OHA acknowledges that due to the timing of the Report submission, it will not reflect data for the entire 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, whether the THW is 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.

h. 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.

i. 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.

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Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth

1. Overview of Solvency Plan

a. Terms used in this Exhibit L are defined in OARs 410-141-5000, 410-141-5095, and 410-141-5260 and are incorporated by reference as though fully set forth in this Exhibit L.

b. Contractor shall follow and use Statutory Accounting Principles in the preparation of all financial statements and reports (OAR 410-141-5015) filed with OHA or DCBS, or both under this Contract or under OAR 410-141-5005 through 410-141-5535, unless OHA's written reporting instructions allow otherwise.

c. 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 will comply with the requirements of this Contract and OAR 410-141-5005 through 410-141-5095.

d. As part of its proof of financial responsibility, Contractor shall provide assurance satisfactory to OHA that Contractor's provisions against the risk of insolvency are adequate to ensure Contractor's compliance with the requirements of this Contract.

e. Pursuant to OAR 410-141-5005, Contractor's demonstration of sound financial management shall include a detailed description of Contractor's Loss Protection Program which shall be submitted to OHA in PDF format (based on a template provided by OHA) via Administrative Notice, as may be requested from time to time. Contractor shall use Exhibit L2 (posted on OHA's CCO Contract Forms Website) as guidance for drafting its Loss Protection Program, which shall include (as applicable) stop loss insurance coverage, reinsurance or such other alternative protection(s) as may be approved by OHA. Contractor's Loss Protection Program shall be subject to OHA review and approval. In the event OHA does not approve Contractor's Loss Protection Program, Contractor shall follow the process set forth in Ex. D, Sec. 5 of this Contract. In the event Contractor makes any material change to its Loss Protection Program prior to or after OHA's initial approval of such Program in Contract Year one, Contractor shall resubmit, via Administrative Notice, the revised Loss Protection Program to OHA for review and approval and include with such documentation, an explanation of the reasons for the change and the effective date of the change. Review and approval of the revised Loss Prevention Program shall follow the same process for initial approval as set forth in this Para. e, Sec. 1 of this Ex. L.

2. NAIC Financial Reporting

a. General Requirements

(1) Contractor acknowledges and agrees that DCBS may act on behalf of OHA under this Contract pursuant to OAR 410-141-5010. Contractor shall respond to informational and other requests of DCBS made in such capacity on the same basis and within the same time limits as would apply if the request were made by OHA.

(2) Contractor shall promptly and truthfully respond, and shall cause all of its officers, employees, Agents, and Subcontractors promptly and truthfully respond to all inquiries made by OHA or by DCBS on behalf of OHA concerning the Work and transactions contemplated by this Contract, together with any other matter presented under or in connection with this Contract, using the form of communication requested by OHA or DCBS, as applicable (OAR 410-141-5010.). Contractor shall ensure all such responses are accurate and complete. Contractor shall be responsible for the truth, accuracy,

timeliness, and completeness of responses submitted by Contractor's officers, employees, Agents, representatives, and Subcontractors.

(3) OHA may require Contractor to produce books, records, accounts, papers, documents, computer, and other electronic or digital records in the possession, custody, or control of Contractor, or Contractor's Affiliates, Agents or representatives that are needed to determine Contractor's financial condition or compliance with Applicable Law, or which are needed to determine Contractor's compliance with this Contract .

(4) Contractor shall file all NAIC A-E Forms as required under the rule and if such conditions exist that require such Forms to be submitted. All such forms shall be submitted to OHA.

(5) Contractor may be required to use specific required reporting forms or items in order to supply information related to financial responsibility, financial solvency, and financial management. OHA or DCBS, as applicable, shall provide Contractor, via Administrative Notice to Contractor's Contract Administrator, with supplemental instructions about the use of these forms.

b. Financial Reports

(1) Contractor shall file its annual (both audited and unaudited) and quarterly financial statements, as well as any other reports that are required under OAR 410-141-5015, with OHA and with the NAIC, unless expressly provided otherwise in this Exhibit L. Contractor shall file its annual and quarterly financial statements, using NAIC Forms and Instructions or in another format as may be requested by OHA from time to time. The NAIC Forms are found at the following URL: https://content.naic.org/industry_financial_filing.htm.

(2) Contractor shall file all of its financial statements electronically with the NAIC. 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 imposed by the NAIC in connection with such filings.

(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 Contractor's latest-submitted set of financial statements. Contractor shall follow the guidelines for amending the previously filed financial statements set forth on the NAIC filings website.

(4) Contractor shall Submit to OHA, via Administrative Notice, executed electronic copies of its financial statement filings simultaneously with its NAIC filings.

c. Annual Financial Statements

(1) Contractor shall submit its annual financial statements on or before April 30 of each Contract Year following the calendar year for which the filing is made.

(a) Contractor's obligation to file its annual financial statements for Contract Year five ending on December 31, 2024, survives termination of this Contract and Contractor shall submit such annual financial statements in accordance with this Para. c, Sec. 2, Ex. L to OHA no later than April 30, 2025.

(2) Contractor's annual financial statement filing shall include an actuarial opinion prepared by a qualified actuary appointed by Contractor's Governing Board, which sets forth the actuary's opinion relating to the statutory reserves reflected in the annual financial statement.

(3) Contractor shall also simultaneously submit, with its annual financial statement filing, a risk-based capital Report prepared and filed by Contractor pursuant to OAR 410-141-5256.

(4) The annual statement filing shall also include a plain-language narrative explanation of the financial statements in the form of a "Management Discussion and Analysis" presentation prepared in accordance with the NAIC Forms and Instructions.

d. Quarterly Financial Statements

Contractor shall submit to OHA, via Administrative Notice, quarterly financial statements on or before May 31, August 31, and November 30 of each Contract Year. Contractor shall file the same with NAIC on the same dates such statements are submitted to OHA. Contractor shall prepare and, as applicable, submit and file the quarterly financial statements using the NAIC Forms and Instructions.

e. Audited Financial Statements

Pursuant to OAR 410-141-5015, Contractor shall submit its audited annual financial statements with OHA no later than June 30 of each Contract Year for the immediately preceding calendar year. Audited Financial Statements shall be provided to OHA via Administrative Notice. Audited financial statements shall be prepared and submitted to OHA in accordance with the requirements of OAR 410-141-5020.

(1) Contractor's obligation to file its audited financial statements for Contract Year five ending on December 31, 2024, survives termination of this Contract and Contractor shall submit such annual audited financial statement in accordance with this Para. e, Sec. 2, Ex. L to OHA no later than June 30, 2025.

3. Supplemental Financial Reporting

a. Contractor shall submit those supplemental annual and quarterly reports that are identified as Ex. L Financial Reporting Templates (which shall be in an Excel workbook format) on the CCO Contract Forms Website. Such supplemental and quarterly reports shall be submitted to OHA via Administrative Notice.

b. Supplemental reporting forms, "Exhibit L Financial Report Template" and "Exhibit L Financial Reporting Supplement SE" (together, the "Exhibit L Supplemental Reports), and other tools for Contractor's solvency plan and financial reporting are available on the CCO Contract Forms Website, and are incorporated by reference as though fully set forth in this Contract.

c. Definitions and instructions for completing and submitting each Report are included in the Ex. L Financial Reporting Template. The Exhibit L Financial Reporting Template also provides instructions as to whether supplemental reports are due quarterly or annually, along with the respective due dates.

d. Contractor shall submit the completed supplemental reports to OHA via Administrative Notice.

4. Other Required Reports

a. Contractor shall submit its Corporate Governance Annual Disclosure Report to OHA, via Administrative Notice, by no later than June 1 of each Contract Year (OAR 410-141-5045).

b. Contractor shall submit a Report of all financial distributions made by Contractor to shareholders, equity members, parent companies and other related parties made during the previous twelve months. Contractor shall submit such Report to OHA, via Administrative Notice, simultaneously with its CGAD Report.

c. Contractor shall submit to OHA its registration and keep current its Form B insurance holding company registration statement (OARs 410-141-5365, 410-141-5370, 410-141-5430, and 410-141-5500). Contractor shall initially submit its Form B registration to OHA within fifteen (15) days after the date Contractor becomes subject to registration, and then thereafter on or before April 30 of each Contract Year. Contractor also shall make the annual Form C filing (OAR 410-141-5435) at the same time as its Form B registration. The Form B and Form C must be submitted via Administrative Notice.

d. Contractor shall submit filings related to, and necessary for securing the Authority's approval of affiliated interest transactions (OAR 410-141-5415).

e. Contractor shall apply for approval of extraordinary dividends and distributions (OAR 410-141-5505). If prior approval of a dividend or distribution is not required, Contractor shall nonetheless provide OHA with written notice of the proposed dividend or distribution within five (5) Business Days following the date on which the dividend or distribution is declared and at least twenty (20) days prior to the date on which the dividend or distribution will be paid.

f. For distributions not covered under Para. e, Sec. 4, Ex. L, Contractor shall provide OHA, via Administrative Notice, with a Report of such financial distributions made by Contractor to Shareholders, equity members, parent companies, or any related parties no later than thirty (30) days after distribution.

5. Assumption of Risk/Private Market Reinsurance

a. Contractor assumes the risk of 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 the provision of 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 OAR 410-141-5005 and 410-141-5050 through 410-141-5075, 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 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 provide OHA, via Administrative Notice, with notice of any change in its stop-loss or reinsurance coverage within thirty (30) days after such change.

(5) Contractor understands and agrees that under no circumstances will a Member be held liable for any payments for any of the following:

(a) 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 Contractor; or

ii. 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 Subcontractors, to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly.

(6) Nothing in this Ex. L, Sec. 4, limits Contractor, OHA, a Provider or Subcontractor from pursuing other legal remedies that will not result in Member personal liability for such payments.

6. Restricted Reserve Requirements

a. Contractor shall (i) establish a Restricted Reserve Account; and (ii) maintain adequate funds in this account to meet OHA's Primary and Secondary Restricted Reserve requirements in accordance with OAR 410-141-5250. Restricted Reserve funds are to be held for the primary purpose of making payments to Providers in the event of 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 Restricted 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 State of Oregon.

b. Restricted Reserve Adequacy

(1) Contractor shall submit to OHA, annually, via Administrative Notice, an account statement for its Restricted Reserve Account. Such account statement shall be submitted by Contractor at the same time as Contractor submits its annual financial statement to OHA on April 30 of each Contract Year and on April 30, 2025.

(2) If at any time, OHA believes that Contractor has inadequate funds in its Restricted Reserve account such that the Restricted Reserve does not meet the requirements in OAR 410-141-5250, OHA will provide written Legal Notice to Contractor in accordance with Ex. D, Sec. 26.

(3) Within thirty (30) days of Contractor's receipt of any Legal Notice by OHA under this Section, Contractor shall do one of the following:

(a) Adjust its Restricted Reserve account balance to the amount specified by OHA; or

(b) If allowed by OHA, develop and submit, for OHA's review and approval, a written action plan to cure the deficiency in its Restricted Reserve; or

(c) File an appeal in writing with OHA, via Administrative Notice, stating in detail the reason for the appeal and submit detailed financial records that support the alternate amount.

(4) If Contractor elects to increase the amount of its Restricted Reserve or, as applicable, file a written action plan, Contractor shall provide OHA with Administrative Notice of its election and written confirmation of the actions taken pursuant to the election.

(5) If Contractor files an appeal, OHA will issue an appeal decision within forty-five (45) days of the receipt of the appeal, which shall be made to Contractor's Contract Administrator via Administrative Notice. The appeal decision by OHA shall be binding upon Contractor and not subject to further appeal.

7. Risk Based Capital and Capital Adequacy Requirements

a. Contractor shall endeavor to maintain its Total Adjusted Capital at no less than 300% of its Authorized Control Level RBC (OAR 410-141-5265).

b. Any deficiency in Contractor's Total Adjusted Capital below a minimum equal to 200% of Contractor's Authorized Control Level RBC shall be subject to OAR 410-141-5270 through 410-141-5285, as applicable.

c. OHA may determine and require Contractor to possess and maintain capital or surplus, or any combination thereof, in excess of the amounts otherwise required by law owing to the type, volume, and nature of business transacted by Contractor. OHA may also determine for good cause that one or more investments claimed by Contractor should be categorized as disallowed assets for purposes of determining the adequacy of Contractor's combined capital and surplus (OAR 410-141-5235). OHA will provide written Legal Notice to Contractor of its determination(s) under this subsection in accordance with Ex. D, Sec. 26.

(1) Within thirty (30) days of Contractor's receipt of a Legal Notice by OHA under this subsection, Contractor shall do one of the following:

(a) Increase its capital and surplus to the amount specified by OHA and provide documentation in support thereof;

(b) Alternatively, and if allowed by OHA, Contractor may develop and submit for the Authority's review and approval a written action plan to cure the deficiency in its capitalization; or

(c) File a written appeal with OHA, via Administrative Notice, stating in detail the reason for the appeal. Contractor shall file the written appeal together with detailed financial records that support the alternate amount.

(2) If Contractor elects to increase capitalization or, as applicable, file a written action plan, Contractor shall provide OHA with Administrative Notice of its election and written confirmation of the actions taken pursuant to the election.

(3) If Contractor files an appeal, OHA will issue an appeal decision within forty-five (45) days after receipt of the appeal, which shall be made to Contractor's Contract Administrator via Administrative Notice. The appeal decision by OHA shall be binding upon Contractor and not subject to further appeal.

8. Sustainable Rate of Growth Requirement

a. 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. Contractor shall annually file a Report with OHA, via Administrative Notice, (i) setting forth Contractor's annual risk adjusted rate of growth, and (ii) explaining the respects in which its growth exceeded or met its growth targets under Contractor's the Exhibit L Financial Reporting Template. Such Report shall be submitted by no later than April 30 of each Contract Year. If Contractor does not achieve the sustainable growth target, OHA 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.

9. Delivery of Reports to OHA

a. Contractor shall submit all Reports required to be delivered to OHA under this Exhibit L via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website.

b. OHA shall require some Reports to be submitted under this Exhibit L of the Contract to be

accompanied by an attestation regarding the truth and accuracy of the submitted Report. In all such events, OHA will provide Contractor with the required attestation form which shall be signed by Contractor's CEO, CFO, or their authorized designee.

10. Contractor Participation in Reporting Alignment Advisory Group

In accordance with Section 54c, Chapter 478, Oregon Laws 2019, Contractor shall designate one representative from Contractor's organization to participate in an advisory group comprised of at least one member from each CCO that has entered into a contract with OHA. The advisory group shall recommend standards for reconciling reporting requirements required by OHA as required under this Contract with those required by NAIC. The recommendations made by the advisory group shall be submitted in a report provided by OHA to the interim committees of the Oregon Legislative Assembly related to health by no later than September 15, 2020. Such report shall include recommendations for (i) reducing redundant or duplicative reporting requirements, and (ii) standard templates for any reporting required by OHA of financial information that is in addition to the financial information required to be reported by the Commissioner of the NAIC OHA shall timely notify Contractor's Contract Administrator, via Administrative Notice, of the advisory group meeting dates, locations, and times and other relevant information related to such meetings.

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Exhibit M – Behavioral Health

Behavioral Health services administered through this 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). Behavioral Health services must be provided to improve the transition of Members from higher levels of care into integrated settings in the Community. Sufficient and appropriate Behavioral Health services must be provided to enable Members to integrate and live successfully in the Community and avoid incarceration and unnecessary hospitalization.

1. Behavioral Health Requirements

With respect to the provision of Behavioral Health Care services Contractor shall do all of the following:

a. Be responsible for providing Behavioral Health services for all Members and Care Coordination for Members accessing non-covered Behavioral Health services in accordance with the applicable terms and conditions of this Contract, including without limitation Ex. B, Part 2.

b. Ensure that Services and supports meet the needs of the Member and address the recommendations stated in the Member's Behavioral Health Assessment.

c. Ensure Members have timely access to care in accordance with OAR 410-141-3515 and the applicable terms and c of this Contract, including without limitation Ex. B, Part 4.

d. Arrange for the provision of Health-Related Services to Members, as required in Ex. K of this Contract, to improve a Behavioral Health condition.

e. Adhere to CMS guidelines regarding Mental Health Parity, as required in Ex. E, Sec. 22 of this Contract.

f. Contractor may Subcontract with Behavioral Health Providers to meet its obligations under this Section 1, Ex. M and any and all other applicable provisions of this Contract relating to the provision of Behavioral Health services. Contractor shall Subcontract with the necessary number of Behavioral Health Providers to ensure it meets all of the foregoing obligations. In the event Contractor is unable to meet the each and every one of its obligations under this Section 1, Ex. M and all other applicable provisions of this Contract relating to Behavioral Health services, Contractor shall take the steps necessary to increase its Behavioral Health Provider Network in order to meet its obligations as set forth herein, which may include requesting assistance from OHA in identifying qualified Behavior Health Providers.

g. Publish on Contractor's website a document designed to educate Members about best practices, care quality expectations, screening practices, treatment options, and other support resources available to Members who have mental health illnesses or Substance Use Disorders. OHA has provided a Guidance Document on the CCO Contract Forms Website that provide details regarding Contractor's obligations regarding this educational document. Contractor shall update the educational document within thirty (30) days of any change affecting its content.

2. Financial Matters Relating to Behavioral Health Services

a. Contractor shall not set a limit for Behavioral Health services within the Global Budget.

b. Contractor shall not establish a maximum financial benefit amount for Behavioral Health services available to a Member.

c. Contractor shall 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).

d. Contractor shall reimburse for covered Behavioral Health services rendered in a primary care setting by a Behavioral Health Provider and shall reimburse for covered physical health services in Behavioral Health care settings, by a medical Provider. Contractor shall reimburse for multiple services provided to a Member on the same day at the same clinic or health care setting.

e. Consistent with OHA's "Rapid Engagement" guidelines, CCO shall not deny payment for a Behavioral Health Provider's Valid Claim solely for the reason that the claim contains a provisional diagnosis, for up to the first three dates of service billed by the same Behavioral Health Provider and provided in an outpatient setting.

f. Contractor may enter into Value Based Payment arrangements with Behavioral Health Providers, as permitted under Ex. H of this Contract.

g. Contractor may cover and reimburse inpatient psychiatric services, not including Substance Use Disorder treatment, at an Institution for Mental Diseases, as defined in 42 CFR 435.1010, provided:

(1) facility is a Hospital providing inpatient psychiatric services;

(2) length of stay is no more than fifteen (15) days during the period of the monthly Capitation Payment;

(3) provision of inpatient psychiatric treatment in an 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 offers the Member the option to access the Covered State Plan Services in accordance with OAR 410-141-3860.

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 and Potential Members who have been previously incarcerated and have Enrolled with, or will be Enrolled with Contractor, after release from jail. 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 provide them to OHA, via Administrative Notice, for review and approval for compliance with this Ex. M as follows: (i) by January 31 of each Contract Year; (ii) upon any material change to such policies and procedures; and (iii) within five Business Days of request, as made by OHA from time to time. Changes in Contractor's Behavioral Health policies and procedures shall not be implemented until approved in writing by OHA. If no changes have been made to Contractor's Behavioral Health policies and procedures since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA, via Administrative Notice, an attestation signed by Contractor's CEO or CFO stating that no changes have been made. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website. OHA will notify Contractor within thirty (30) days from submission of the approval status of its Behavioral Health policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review. In the event that OHA does not approve such policies and procedures for failure to comply with this Ex. M, Contractor shall 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, Sec. 3, Para. b, Sub. Para. (6) of this Contract.

c. In accordance with Ex. B, Part 2, Sec. 3, Para. b, Sub. Para. (5), permit Members to obtain Medication-Assisted Treatment for SUD, including opioid and opiate use disorders, for up to thirty (30) days without first obtaining Prior Authorization for payment.

d. 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.

e. Make a Prior Authorization determination within three (3) days of a request for non-emergent Behavioral Health hospitalization or residential care.

f. 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.

g. Not apply more stringent utilization or Prior Authorization standards to Behavioral Health services, than standards that are applied to medical/surgical benefits.

h. 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 410-141-3515. 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 410-141-3515.

6. Screening Members

Contractor shall require Participating Providers to 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. Screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, Transportation needs, safety needs and home visiting).

c. Screen Members for, and provide, Medically Appropriate and Evidence-Based treatments for Members who have both mental illness and Substance Use Disorders.

d. 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. Screen Members and provide prevention, early detection, brief intervention and Referral to Behavioral Health services in any of the following circumstances:

(1) At an initial contact or during a routine physical exam;

(2) At an initial prenatal exam;

(3) When the Member shows evidence of Substance Use Disorders or abuse;

(4) When the Member over-utilizes Covered Services; and

(5) When a Member exhibits a reassessment trigger for Intensive Care Coordination needs.

7. Substance Use Disorders

Contractor shall:

a. Provide SUD services to Members, which include Outpatient, intensive Outpatient, Medication Assisted Treatment including opiate substitution services, and residential, and withdrawal management services, consistent with OAR Chapter 309, Divisions 18, 19 and 22 and Chapter 415, Divisions 20 and 50.

b. Inform all Members, using Culturally and Linguistically Appropriate means, that SUD services are Covered Services consistent with OAR 410-141-3585.

c. Provide Culturally and Linguistically Appropriate alcohol, tobacco, and other drug abuse prevention/education and information that reduce Members' risk to SUD. Contractor's prevention program shall meet or model national quality assurance standards. Contractor shall have mechanisms to Monitor the use of its preventive programs and assess their effectiveness on Members.

d. Provide Culturally and Linguistically Appropriate SUD services for any Member who meets the most current American Society of Addiction Medicine (ASAM) placement criteria for:

(1) Outpatient, intensive Outpatient, residential, detoxification, and Medication Assisted Treatment including opiate substitution treatment, regardless of prior alcohol or other drug treatment or education; and

(2) Specialized programs in each Service Area in the following categories: drug court referrals, Child Welfare referrals, Job Opportunities and Basic Skills (**"JOBS"**) referrals, and Referrals for persons with co-occurring disorders.

e. Ensure that specialized, Trauma Informed, SUD services are provided in environments that are Culturally and Linguistically Appropriate, designed specifically for the following groups:

(1) Adolescents, taking into consideration adolescent development,

(2) Women, and women's specific issues,

(3) Ethnically and racially diverse groups,

(4) Intravenous drug users,

(5) Individuals involved with the criminal justice system,

(6) Individuals with co-occurring disorders,

(7) Parents accessing residential treatment with any accompanying dependent children, and

(8) Individuals accessing residential treatment with Medication Assisted Therapy.

f. Where Medically Appropriate, provide detoxification in a non-Hospital facility. All such facilities or programs providing detoxification services must have a certificate of approval or license from OHA in accordance with OAR Chapter 415, Division 12.

g. Provide to Members receiving SUD services, to the extent of available Community resources and as Medically Appropriate, information and Referral to Community services which may include but are not limited to: child care, elder care, housing, Transportation, employment, vocational training, educational services, mental health services, financial services, and legal services.

h. In addition to any other confidentiality requirements described in this Contract, comply with federal confidentiality laws and regulations (42 CFR Part 2) governing the identity and medical/Client records of Members who receive SUD services.

8. Assertive Community Treatment

a. Contractor shall require that a Provider or 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, 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 living.

b. 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, and shall:

(1) Document efforts to provide ACT to individuals who initially refuse ACT services and efforts to accommodate their concerns.

(2) Provide alternative Evidence-Based intensive services if Member continues to decline participation in ACT, which must include coordination with an Intensive Care Coordinator.

c. If Contractor lacks Providers to provide ACT services, Contractor shall notify OHA and develop a plan to develop additional Providers in accordance with OAR 410-141-3515.

(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. For Members with Severe and Persistent Mental Illness (SPMI), Contractor shall ensure that:

(1) Members are assessed to determine eligibility for ACT.

(2) ACT services are provided in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255.

(3) Additional ACT capacity is created within Contractor's Service Area as services are needed in accordance with OAR 410-141-3515.

e. Contractor shall ensure all denials of ACT services are:

(1) Based on established, Evidence-Based medical necessity criteria;

(2) Recorded and compiled in a manner that allows denials to be accurately reported out as Medically Appropriate or inappropriate; and

(3) Follow the Notice of Adverse Benefit Determination process for all denials in accordance with the applicable sections of Ex. I of this Contract.

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. Peer Delivered Services and Outpatient Behavioral Health Services

e. Contractor shall inform Members of and encourage utilization of Peer Delivered Services, including Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, Youth Support Specialist, or other Peer Specialist, in accordance with OAR 309-019-0105.

b. Contractor shall encourage utilization of PDS by providing Members with information, which must include a description of PDS and how to access it, a description of the types of PDS Providers, an explanation of the role of the PDS Provider, and ways that PDS can enhance Members' care.

c. Contractor may utilize PDS in providing other Behavioral Health services such as ACT, crisis services, Warm Handoffs from Hospitals, and services at Oregon State Hospital.

d. Contractor shall provide Outpatient Behavioral Health Services that include, but are not limited to:

(1) Specialty programs which promote resiliency and rehabilitative functioning for individual and Family outcomes; and

(2) Assertive Community Treatment (ACT), enhanced care services, enhanced care outreach services, Wraparound, behavior supports, crisis care, respite care, and Intensive Outpatient Services and Supports, and IIBHT.

e. Outpatient Behavioral Health Services provided by Contractor must, regardless of location, frequency, intensity or duration of services, and as Medically Appropriate:

(1) Include assessment, evaluation, treatment planning, supports and delivery;

(2) Be Trauma Informed; and

(3) Include strategies to address environmental and physical factors, Social Determinants of Health and Equity, and neuro-developmental needs that affect behavior.

10. Behavioral Health Crisis Management System

a. Contractor shall establish a crisis management system, including 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 410-141-3840, 42 CFR 438.114, and the applicable section of Ex. B, Part 2 of this Contract.

b. The crisis management system must provide an immediate, initial and limited duration response for potential Behavioral Health emergency situations or emergency situations that may include Behavioral Health conditions, including:

(1) Screening to determine the nature of the situation and the Member's immediate need for Covered Services;

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

(3) Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;

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

(5) Linkage with public sector crisis services, such as 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. Contractor shall ensure access to Mobile Crisis Services and crisis hotline for all Members in accordance with OAR 309-019-0105, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute care facility.

e. Contractor shall establish a written Quality Improvement plan for the crisis management system to address the requirements identified in OAR 410-141-3840 and provide the Quality Improvement plan to OHA upon request.

11. Care Coordination / Intensive Care Coordination

a. Contractor shall provide Care Coordination and Intensive Care Coordination for Members with Behavioral Health disorders in accordance with OAR 410-141-3860 and 410-141-3870 and the applicable sections in Ex. B, Parts 2 and 4 of this Contract.

b. Contractor shall ensure all Care Coordinators work with Provider team members to coordinate integrated care. This includes but is not limited to coordination of physical health, Behavioral Health, intellectual and developmental disability, DHS, Oregon Youth Authority, Social Determinants of Health, and Ancillary Services.

c. Contractor shall ensure coordination and appropriate Referral to ICC to ensure that Member's rights are met and there is post-discharge support.

d. Contractor shall authorize and reimburse for ICC Services, in accordance with OAR 410-141-3860 and 410-141-3870.

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. Contractor shall enter into and maintain a written agreement with the Local Mental Health Authority in Contractor's Service Area in accordance with ORS 414.153. The agreement shall include, without limitation, all of the terms and conditions set forth in ORS 414.153(4) and shall require Contractor:

(1) To coordinate and collaborate on the development of the Community Health Improvement Plan with the local CMHP for the delivery of mental health services in accordance with ORS 430.630.

(2) To develop a Comprehensive Behavioral Health plan for Contractor's Service Area in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, families, housing authorities, housing providers, courts). Such plan must comply with ORS 430.630(9)(b)

(a) Contractor shall provide OHA, via Administrative Notice, with its CBH Plan for review and approval on January 2, 2021. In the event OHA determines that Contractor's CBH Plan does not comply with ORS 430.630(9)(b) and this Contract, Contractor shall follow the process set forth in Sec. 5 of Ex. D.

(b) Contractor shall update its CBH Plan upon request. All such revised CBH Plans will be subject to review and approval by OHA in accordance with SubPara. (2)(a) above of this Para. a, Sec. 12, Ex. M of this Contract.

13. Oregon State Hospital

a. Contractor shall be financially responsible for Members on the waitlist for OSH.

b. Contractor shall share financial risk for Members in OSH beginning in Contract Year three (2022).

c. Contractor shall, in accordance with OAR 309-091-0000 through 309-091-0050:

(1) Coordinate with applicable Subcontractors as needed regarding discharges for all adult Members with SPMI;

(2) Coordinate care for Members during discharge planning for the return to Home Contractor or to the Receiving Contractor if Member will be discharged into a different Service Area when Member has been deemed ready to transition;

(3) Arrange for both physical and Behavioral Health care Services Care Coordination;

(4) Provide Case Management Services, Care Coordination and discharge planning for timely follow up to ensure Continuity of Care;

(5) Coordinate with OHA regarding Members who are presumptively or will be retroactively enrolled in Oregon Health Plan upon discharge;

(6) Arrange for all services to be provided post-discharge in a timely manner; and

(7) Provide access to Evidence-Based intensive services for adult Members with SPMI discharged from OSH who refuse ACT services.

d. Discharges from OSH shall not be to a secure residential treatment facility unless Medically Appropriate. No Member shall be discharged to a secure residential treatment facility without the expressed prior written approval of the Director of OHA or 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. 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. Contractor shall develop and implement an Individualized Management Plan for a Member who has two (2) or more visits to an Emergency Department within a six (6)-month period.

c. Contractor shall work with Hospitals to obtain data on Emergency Department utilization for Behavioral Health reasons and length of time in the ED. Contractor shall develop remediation plans with Hospitals with significant numbers of ED stays longer than 23 hours.

d. Contractor shall work with 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. Involuntary Psychiatric Care

a. 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: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9550.pdf in lieu of involuntary treatment.

b. Contractor shall employ the use Emergency Psychiatric Holds consistent with ORS 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. Contractor shall only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0740.

d. Contractor shall comply with ORS Chapter 426 and OAR 309-033-0200 through 309-033-0740 for involuntary Civil Commitment of those Members who are civilly committed under ORS 426.130.

e. Contractor shall ensure that any involuntary treatment provided under this Contract is provided in accordance with ORS Chapter 426 and OAR 309-033-0200 through 309-033-0440 and shall

coordinate with the CMHP Director in Contractor's Service Area in assuring that all 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. Long Term Psychiatric Care

a. Contractor will be financially responsible for LTPC benefit for Members after Contract Year two (2021), with a timeline to be determined by OHA.

b. For a Member age 18 or older:

(1) The Member is appropriate for LTPC when:

(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

(b) Member has received a comprehensive psychiatric and medical assessment, treatment with medications for at least seven (7) days at an adequate dose, where both criteria are described in OAR 309-091-0015(1), and if Medically Appropriate, establishment and use of Involuntary Administration of Significant Procedures as described in OAR 309-033-0640.

(2) If Contractor identifies a Member, age 18 or older, as appropriate for LTPC, Contractor shall request a LTPC determination from the OSH Extended Care Coordinator as described in the procedure for LTPC Determinations for Members 18 or Older available on the CCO Contract Forms Website. Contractor shall make this request by submitting a Clinical Review Packet, which consists of the completed Request for LTPC Determination form, completed Community Questionnaire, and supporting documents described in the procedure for LTPC determinations. The OSH Extended Care Coordinator will respond to Contractor no more than three (3) Business Days following the date that the Coordinator receives the Clinical Review Packet from Contractor.

(3) OHA will cover the cost of LTPC of Members age 18 or older 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. If a Member is determined appropriate for LTPC, the effective date of such determination will be:

(a) Three (3) Business Days after the date that the OSH Extended Care Coordinator receives the Clinical Review Packet from Contractor; or

(b) In cases where OHA and Contractor mutually agree on a date other than as identified in (a) above, the date mutually agreed upon; or

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

(4) In the event Contractor and OSH Admissions Office staff disagree about whether a Member is appropriate for LTPC, Contractor may request, within three (3) Business Days of receiving notice of the LTPC determination, review by an OSH 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 in Sub.Para. (3) above of this Para. b., Sec. 16, Ex. M. The cost of the clinical review will be divided equally between Contractor and OHA.

(5) Contractor shall work with the appropriate OHA Team or designee in managing admissions, discharges and transitions from LTPC for Members who require LTPC at a State Facility, to ensure that Members are served in and transition into the most appropriate, independent, and integrated Community-based setting possible.

(6) 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-based setting possible consistent with Member choice.

c. For a Member age seventeen (17) or younger:

(1) If Contractor identifies a Member who is age seventeen (17) or younger is appropriate for LTPC 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 Forms Website;

(2) 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) Contractor shall work with the HSD Child and Adolescent Mental Health Specialist in managing admissions and discharges to LTPC Secure Children's Inpatient Program and Secure Adolescent Inpatient Program.

(4) The Member will remain enrolled with Contractor for delivery of SCIP and SAIP services. Contractor shall 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 Provider, services provided by LTPC service Provider and transition and discharge planning. This should include collaborative relationships with all system partners to achieve Continuity of Care. Contractor shall ensure that utilization of LTPC is reserved for the most Acute and complex cases and only for the period of time necessary and Medically Appropriate to remediate symptoms that led to admission.

(5) For the Member and the parent or guardian of the Member, the Care Coordinator and the Child and Family Team will work to assure timely discharge and transition from a psychiatric residential treatment facility to the most appropriate, independent and integrated community-based setting possible.

17. Acute Inpatient Hospital Psychiatric Care

a. Contractor shall provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC and for whom it is Medically Appropriate.

b. Contractor shall submit required data through the Acute Care reporting database as instructed by OHA.

c. 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 Member has been committed, there is good cause as described in OAR 309-033-0640., and the requirements of OAR 309-033-0640. have been met.

d. Contractor shall develop and implement an Individualized 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.

e. Contractor shall ensure all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer, or other Community Provider prior to discharge, and that all such Warm Handoffs are documented.

f. Contractor shall ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate Behavioral Health and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR 309-032-0850. through 309-032-0870.

g. Contractor shall ensure all adult Members receive a follow-up visit with a Community Behavioral Health 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.

h. Contractor shall coordinate with system Community partners to ensure Members who are 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 Behavioral Health agency to ensure these Members are linked to housing in an integrated setting, consistent with the Member's treatment goals, clinical needs and informed choice.

i. 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. The housing 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 Member's treatment goals, clinical needs, and informed choice. Contractor shall notify, or require the Acute Care Psychiatric Hospital to notify the Community Provider to facilitate the implementation of the plan for housing.

18. Women's Health

a. Contractor shall 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.

b. Contractor shall ensure pregnant women receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3515.

19. Children and Youth Behavioral Health Services

a. Contractor shall provide services to children, young adults and families that are sufficient in frequency, duration, location, and type that are convenient to the youth and Family. Services should 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 410-141-3515.

c. Contractor shall maintain an intensive and flexible service continuum for children and youth who are at risk of placement disruption, school failure, criminal involvement, becoming Homeless or other undesirable outcomes due a Behavioral Health disorder.

d. Contractor shall utilize Evidence-Based Behavioral Health interventions for the Behavioral Health needs of Members who are children and youth.

e. Contractor shall ensure Members have access to Evidence-Based Dyadic Treatment and treatment that allows children to remain living with their primary parent or guardian. Dyadic treatment is specifically designed for children eight (8) years and younger.

f. Contractor shall ensure that children in the highest levels of care (subacute, residential or day treatment) received Family treatment with their caregivers provided that no Social Determinants of Health or other conditions will preclude such caregivers from actively and meaningfully participating in Family treatment. Contractor shall also ensure that children in the highest levels of care (subacute, residential or day treatment) have a psychological evaluation current within the past twelve months and receive a child psychiatric evaluation and ongoing psychiatric care in accordance with OAR 309-022-0155. Should a child under age six (6) be in day treatment, subacute, or residential care settings, a developmental evaluation shall be done in addition to a psychological evaluation, if clinically indicated.

g. Contractor shall ensure ICC is available, at a minimum, for Members seventeen (17) and younger for any of the following situations, in accordance with OAR 410-141-3860 and 410-141-3870:

(1) Children and youth placed in a correctional facility solely for the purpose of stabilizing a Behavioral Health condition.

(2) Children and youth placed out of Contractor's Service Area in behavior rehabilitation service programs under the jurisdiction of Child Welfare.

(3) 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 or upon discharge from such care.

h. 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 (CF 0499), Contractor shall also coordinate with such Member's parent or legal guardian.

i. Contractor shall develop and maintain written policies and procedures relating to the use of psychotropic drugs for children, especially those in the custody of DHS, in accordance with Para. d, Sec. 7, Ex. B, Part 2 of this Contract.

j. 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.

k. 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 require their Providers to provide a 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.

l. Contractor shall ensure that 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.

m. Wraparound Supports: Contractor shall provide Wraparound supports to eligible Members in accordance with OAR 309-019-0325 and 309-019-0326, including, without limitation the requirement that ensures the ratio of Care Coordinators, Family Support Specialists, and Youth Support Specialists to families served shall not exceed a ratio of no more than 1:15.

(1) Contractor shall develop and maintain written Wraparound policies and procedures which must include, without limitation:

(a) Processes Wraparound Teams must follow when selecting services and supports and identifying those which will require the prior approval of the Providers before receiving such services and supports;

(b) Processes Wraparound Teams will be required to follow in order to obtain prior approval, from Contractor or its Subcontractor, for those services and supports that require such approval; and

(c) A plan that details how Contractor will meet the needs of children and adolescents in Contractor's Service Area who are eligible to receive Wraparound services.

(2) Contractor may contact OHA's Wraparound and System of Care Coordinator in the Child and Family Behavioral Health Unit for technical assistance with drafting its Wraparound policies and procedures.

(3) If Contractor lacks Provider capacity to provide Wraproud, Contractor shall notify OHA and develop a plan to increase Provider capacity.

(a) Lack of capacity may not be a basis to allow Members who are eligible for Wraproud supports to be placed on a waitlist.

(b) No Member on a waitlist for Wraproud may be without such services for more than fourteen (14) days.

n. Contractor shall submit its Wraparound policies and procedures to OHA for review and approval as follows: (i) by January 31 of each Contract Year; (ii) upon any material change to such policies and procedures; and (iii) within five Business Days of request, as made by OHA from time to time. Changes in Contractor's Wraparound policies and procedures shall not be implemented until approved in writing by OHA. If no changes have been made to Contractor's Wraparound policies and procedures since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA, via Administrative Notice, an attestation signed by Contractor's CEO or CFO stating that no changes have been made. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website. OHA will notify Contractor within thirty (30) days from submission of the approval status of its Wraparound policies and procedures; OHA will notify Contractor within the same period if additional time is needed for review. In the event that

OHA does not approve Contractor's Wraparound policies and procedures, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

o. Contractor shall provide Wraparound in compliance with the following:

(1) Contractor shall maintain sufficient funding and resources to implement Wraparound Care Coordination Services to 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.

(2) Contractor shall convene and maintain a Wraparound Review Committee in accordance with OAR 309-019-0325.

(3) Contractor shall ensure the implementation of Fidelity Wraparound by requiring Wraparound Providers to hire and train the following staff:

(a) Wraparound Care Coordinator;

(b) Wraparound supervisor;

(c) Wraparound Coach;

(d) Youth Peer Delivered Service Provider;

(e) Family Peer Delivered Service Provider; and

(f) Peer Delivered Service Provider supervisors.

(4) Contractor shall ensure Behavioral Health 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.

(5) OHA will review Contractor's Behavioral Health data and conduct Fidelity reviews in order to determine whether Contractor has complied with its Wraparound obligations under this Para. o, Sec. 19, Ex. M. Fidelity reviews will occur as follows: (i) in accordance with OAR 309-019-0326(15), (ii) in connection with receipt of Wraparound Fidelity Tool Index Tool (WFIEZ) used by OHA, (iii) once per biennium, and (iii) as may be requested from time to time by OHA. OHA shall have the right to request, and upon any such request, Contractor shall promptly provide OHA with, information and documents created as a result of the provision of Wraparound Services, including, without limitation, the documentation generated as a result of assessments conducted under OAR 309-019-0326(9)-(11) and any other information and documentation related to its compliance review. OHA shall also have the right to conduct interviews of those families enrolled in Wraparound services, Wraparound coaches, and other third-parties involved in the provision and authorization of Wraparound services including, without limitation.

p. Contractor shall develop and implement Cost-Effective comprehensive, person-centered, individualized, and community-based Child and Youth Behavioral Health services for Members, using of System of Care (SOC) values.

(1) Contractor shall establish and maintain a functional System of Care in its Service Area.

(2) Contractor shall have a functional SOC governance structure.

(a) The SOC governance structure shall consist of a Practice Level Workgroup, Advisory Committee, and Executive Council with a goal of meaningful youth and family representation.

(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 work with any and all Contractors within the same Service Area (if applicable) to ensure a singular, collaborative System of Care structure for the Service Area.

(c) The Practice Level Workgroup shall review Wraparound practice barriers, remove barriers when possible, and submit system 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) The Practice Level Workgroup must consist of representatives of Providers who supervise individuals from local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) and must include meaningful participation from youth and Family members.

(e) The Advisory Committee shall advise on policy development, implementation, and provide oversight using a strategic plan. It shall respond to system barriers which the Practice Level Workgroup cannot resolve, making recommendations to the Executive Council as needed.

(f) The Advisory Committee must consist of representatives of Providers, local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) all of whom must have authority to make program level financial and policy changes, and must include meaningful participation from youth and Family members.

(g) The Executive Council shall develop and approve policies and shared decision-making regarding funding and resource development, review project outcomes, and identify unmet needs in the ccommunity to support the expansion of the service array.

(h) The Executive Council must consist of representatives of Contractor, Providers, local public child serving agencies (Child Welfare, education, juvenile justice, OYA, Tribal communities, intellectual/developmental disabilities, Behavioral Health) all of whom must have authority to make program level financial and policy changes, and must include meaningful participation from youth and Family members.

(3) Contractor shall develop an SOC Policy that addresses the components listed below. Contractor's SOC Policy shall be approved by its SOC Executive Council. Contractor shall submit its SOC Policy, which has been approved by its SOC Executive Council, to OHA for review and approval as follows:

(a) by February 28 in Contract Year two (2021) and by January 31 in each subsequent Contract Year;

(b) upon any material change to such policy; and

(c) within five Business Days of request, as made by OHA from time to time.

(4) Changes in Contractor's SOC Policy shall not be implemented until approved in writing by OHA. If no changes have been made to Contractor's SOC Policy since last approved by OHA, Contractor may, for its annual January 31 submission, submit to OHA, via Administrative Notice, an attestation signed by Contractor's CEO or CFO stating that no changes have been made. Contractor shall make the attestation using the Attestation form located on the CCO Contract Forms Website. OHA will notify Contractor within thirty (30) days from submission of the approval status of its SOC Policy; OHA will notify Contractor within the same period if additional time is needed for review. In the event that OHA does not approve Contractor's SOC Policy, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

(a) Contractor's SOC Policy shall address the following components:

i. 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.

(5) Contractor shall, for each Contract Year, prepare and submit quarterly reports for the System of Care Statewide Steering Committee to OHA, via Administration Notice, within thirty (30) days after the end of each calendar quarter. Each Report must include the following information:

(a) Barriers that were submitted by the community to the appropriate committee within the SOC governance structure;

(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) Data-informed priorities for the following Contract Year.

q. The Child and Adolescent Needs and Strengths Comprehensive Screening – Oregon ("CANS Oregon") uses a multi-purpose tool developed to support decision making, including level of care and service planning, to facilitate Quality Improvement initiatives, and to allow for the Monitoring of outcomes of services and supports.

(1) Contractor shall ensure only Providers who have been certified by the Praed Foundation for administering the CANS Oregon (as found at https://www.schoox.com/login.php) shall administer CANS Oregon to Members.

(2) Contractor shall ensure a CANS Oregon is administered to each Member enrolled in Fidelity Wraparound. Contractor shall complete a CANS Oregon within thirty (30) days of initial program enrollment, every ninety (90) days thereafter, after a significant event, and upon exit from the Fidelity Wraparound program.

(a) Contractor shall ensure a CANS Oregon is administered to each Member age seventeen (17) or younger in Child Welfare, regardless of enrollment in Fidelity Wraparound, and entry of the CANS data into OR-Kids, the online data system for youth in Child Welfare, within sixty (60) days of notification that the Member is entering foster care or from date of Referral from DHS caseworker.

20. Intensive In-Home Behavioral Health Treatment

a. Contractor shall provide access to Intensive In-Home Behavioral Health Treatment (IIBHT) services for all eligible Members age twenty (20) and younger in accordance with OARs 309-019-0167, 410-172-0650, and 410-172-0695.

(1) IIBHT services are community-based services that are delivered in the Member's home (e.g., biological home, foster home, group home), school, or other community location determined by the Member.

(2) IIBHT services must be provided by Providers certified by OHA under OAR 309-019-0167 for IIBHT. Such certification requires the Provider to also be certified by OHA for Outpatient Behavioral Health services.

(3) A Member is eligible for IIBHT if they have a primary mental health diagnosis funded on the Prioritized List of Health Services and require intensive services to provide for community stabilization, to prevent the need for facility-based care, or as step-down to the community from facility-based care.

(a) Contractor shall not require a Member to participate in any other programs or treatments as a condition of eligibility for IIBHT.

(b) Contractor may offer Wraparound or Intensive Care Coordination to a Member who receives IIBHT but shall not regard a Member ineligible for IIBHT if Wraparound or Intensive Care Coordination is not indicated.

(4) Contractor shall ensure all Members receiving IIBHT services have an Assessment, Crisis and Safety Plan, and Service Plan completed in accordance with OAR 309-019-0167. Contractor shall also ensure that all contracted IIBHT Providers are able to offer Members the following services:

(a) Child psychiatric services provided by:

i. A Board Eligible or Certified Child and Adolescent Psychiatrist; or

ii. A Psychiatric Nurse Practitioner (PNP) under the weekly consultation and quarterly supervision of a Board Eligible or Certified Child and Adolescent Psychiatrist.

(b) Individual Therapy;

(c) Family Therapy;

(d) Skills Training;

(e) Case Management;

(f) Peer Delivered Services; and

(g) In home proactive support and crisis response available 24 hours each day.

(5) No fewer than four (4) hours of in-person planned program services must be offered to the Member each week, as identified within the Assessment and Service Plan;

(6) Members must be considered for IIBHT services without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, intellectual and/or developmental disability, IQ score, or physical disability.

(7) If Contractor lacks Provider capacity to provide IIBHT services, Contractor shall notify OHA and develop a plan to increase Provider capacity.

(a) Lack of capacity may not be a basis to allow Members who are eligible for IIBHT to be placed on a waitlist.

(b) No Member eligible for IIBHT services may be without such services for more than fourteen (14) days.

(8) Contractor shall ensure contracted IIBHT Providers are trained in the RedCap System to enter participant and outcome data. Trainings will be provided by an OHA-approved contractor.

(9) Contractor shall ensure contracted IIBHT Providers enter participant and outcome data into the RedCap System for Members in IIBHT within seven (7) days of program entry and within seven (7) days prior to discharge as required by OAR 309-019-0167.

(10) Contractor shall authorize IIBHT services in accordance with OAR 410-172-0695.

(11) Contractor shall maintain sufficient funding and resources to implement the IIBHT program for Members seventeen (17) years and younger for any Member meeting entry criteria.

21. Reporting Requirements

a. Contractor shall submit an annual Behavioral Health Report to OHA each Contract Year on Behavioral Health metrics. Contractor shall submit such Report using the template provided by OHA, which is located on the CCO Contract Forms Website. OHA will also provide a Guidance Document to assist Contractor in completing its Behavioral Health metrics Report. Such Guidance Document is located on the CCO Contract Forms Website. OHA reserves the right to update the required reporting metrics and any associated Guidance Documents for Contract Years two (2) through five (5). The Behavioral Health Report shall be delivered annually to OHA, via Administrative Notice, on March 31 of each Contract Year for the preceding Contract Year.

b. Metrics to be included in the Behavioral Health Report will be determined by OHA and will assess:

(1) 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 for review and approval via Administrative Notice. 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 shall 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. Contractor shall ensure that its Subcontractors and Participating Providers supply all required information to support the reporting process described in this section.

h. Contractor shall ensure all Behavioral Health Providers that receive Certificates of Approval or a license from HSD enroll 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.

22. Providers

a. Contractor shall ensure Contractor's employees, Subcontractors, and Providers are trained in 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.

b. Contractor shall ensure Contractor's employees, Subcontractors, and Providers of Behavioral Health services are trained in recovery principles, motivational interviewing. Contractor shall ensure its employees, Subcontractors, and Providers of Behavioral Health services provide regular, periodic oversight and technical assistance on these topics to Providers.

c. Contractor shall require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACE), trauma and resiliency in a Culturally and Linguistically Appropriate manner, using a Trauma Informed framework.

d. Contractor shall ensure that Providers who have a waiver under the Drug Addiction Treatment Act of 2000 and 42 CFR Part 8, are permitted to treat and prescribe buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.

e. Contractor shall ensure that employees or Providers who evaluate Members for access to, and length of stay in, Substance Use Disorders programs and services use the most current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders 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.

f. Contractor shall recognize OHA's licensing standards for mental health and substance use disorder programs as the minimum necessary requirements to enter the Provider Network.

g. Contractor shall require its Behavioral Health residential treatment Participating Providers, including those providing sub-acute psychiatric services, to (i) enroll in OHA's Centralized Behavioral Health Provider Directory, (ii) be part of the necessary trainings and ongoing technical assistance provided by OHA or designee, and (iii) enter data required for the Directory in a timely and accurate manner in order to provide up-to-date capacity information to users of the Directory.

23. Mental Health Parity Reporting Requirements

a. 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.

b. 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:

(1) Annually by no later than March 30 of the year following the reporting year;

(2) Within five (5) Business Days after there is a significant or material change in Contractor's processes or operations that affects parity;

(3) Within five (5) Business Days after Contractor adds or eliminates a Subcontractor Delegated process or operations that affects parity; and

(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. 23, 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.

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Exhibit C – Attachment 1

CCO Specific Rates

Exhibit D – Attachment 1

Deliverables and Required Notices