OREGON HEALTH PLAN

Amended and Restated

HEALTH PLAN SERVICES CONTRACT

Coordinated Care Organization

Contract # «Medicaid_Contract_»-«Next_M_amend_»

with

«Registered_Name» «Registered_ABN»

Table of Contents

~~General Provisions ..... 9~~
~~1. Annual Approval; Duration of Contract ..... 9~~
~~2. Contract Administrators ..... 10~~
~~3. Enrollment Limits and Service Area ..... 10~~
~~4. Entire Contract; Administration of Contract; Interpretation of Contract ..... 11~~
~~5. Contractor Data and Certification ..... 14~~
~~Exhibit A – Definitions ..... 17~~
~~Exhibit B – Statement of Work – Part 1 – Governance and Organizational Relationships ..... 51~~
~~1. Governing Board and Governance Structure ..... 51~~
~~2. Clinical Advisory Panel ..... 51~~
~~3. Tribal Liaison ..... 51~~
~~4. Innovator Agent and Learning Collaborative ..... 52~~
~~Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services ..... 54~~
~~1. Covered Services ..... 54~~
~~2. Provision of Covered Services ..... 54~~
~~3. Authorization or Denial of Covered Services ..... 57~~
~~4. Covered Service Component: Crisis, Urgent and Emergency Services ..... 61~~
~~5. Covered Service Component: Non-Emergent Medical Transportation (NEMT) ..... 62~~
~~6. Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care ..... 72~~
~~7. Covered Service Component: Medication Management ..... 74~~
~~8. Covered Service Components: Other Services ..... 78~~
~~9. Non-Covered Health Services with Care Coordination ..... 79~~
~~10. Non-Covered Health Services without Care Coordination ..... 81~~
~~11. In Lieu of Services (ILOS) ..... 81~~
~~12. Family Connects Oregon ..... 88~~
~~13. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) ..... 88~~
~~14. Healthier Oregon Program ..... 90~~
~~15. Health-Related Social Needs Services: Member Identification, Screenings, Authorizations, Denials, and Notifications ..... 91~~
~~16. Health-Related Social Needs Services: Administrative and Delivery Processes; HRSN Service Delivery Network Requirements ..... 100~~
~~17. OHP Bridge - Basic Medicaid Program ..... 111~~
~~18. Reentry Health Care Services ..... 111~~
~~Exhibit B – Statement of Work – Part 3 – Patient Rights and Responsibilities, Engagement and Choice ..... 114~~
~~1. Member and Member Representative Engagement in Member Health Care and Treatment Plans . 114~~
~~2. Member Rights and Responsibilities under Medicaid ..... 114~~
~~3. Provider's Opinion ..... 118~~
~~4. Informational Materials for Members and Potential Members: General Information and Education ..... 118~~
~~5. Informational Materials for Members and Potential Members: Member Handbook ..... 121~~

6. Informational Materials for Members and Potential Members: Provider Directory 122
7. Grievance and Appeal System 124
8. Enrollment 124
9. Disenrollment 125
10. Member Benefit Package Changes 126
11. Enrollment Reconciliation 126
12. Identification Cards 127
13. Marketing to Potential Members 127
Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems 129
1. Integration and Coordination 129
2. Access to Care 130
3. Delivery System and Provider Capacity 135
4. Provider Selection 137
5. Credentialing 138
6. Patient Centered Primary Care Homes 140
7. Indian Health Care Providers 141
8. Care Coordination 141
9. Care Integration 142
10. Delivery System Dependencies 143
11. Evidence-Based Clinical Practice Guidelines 144
12. Subcontract Requirements 144
13. Minority-Owned, Woman-Owned and Emerging Small Business Participation 151
14. Adjustments in Service Area or Enrollment 152
[Exhibit B, Parts 5 through 7 are reserved.] 155
Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations 156
1. Record Keeping Requirements 156
2. Privacy, Security, and Retention of Records; Breach Notification 157
3. Access to Records 158
4. Payment Procedures 158
5. Claims Payment 159
6. Medicare Payers and Providers 162
7. Eligibility Verification for Fully Dual Eligible Members 163
8. All Payer All Claims Reporting Program 164
9. Cost Growth Target Program 164
10. Health Care Market Oversight Program 164
11. Administrative Performance Program: Valid Encounter Claims Data 164
12. Encounter Data Submission Processes 166
13. Additional Encounter Data Submission Requirements: Non-Pharmacy Encounter Data 167
14. Pharmacy Encounter Data 167
15. Administrative Performance Standard 168
16. Drug Rebate Program 169
17. Drug Rebate Dispute Resolution Process 170
18. Third Party Liability, Excluding Personal Injury Liens 170
19. Personal Injury Liens 173
20. Disclosure of Ownership Interests 176
21. Disclosure of Other Ownership Interests 178

~~22. Certain Changes in Control Requiring Pre-Approval from OHA ..... 178~~
~~23. Subrogation ..... 180~~
~~24. Contractor's Governing Board ..... 180~~
~~**Exhibit B – Statement of Work – Part 9 – Program Integrity ..... 181**~~
~~1. Monitoring and Compliance Review - Overview ..... 181~~
~~2. Conditions That May Result in Sanctions ..... 181~~
~~3. Range of Sanctions Available ..... 183~~
~~4. Amount of Civil Money Penalties: 42 CFR § 438.704 ..... 184~~
~~5. Temporary Management ..... 185~~
~~6. Corrective Action Plan ..... 186~~
~~7. Civil Money Penalties: OAR 410-141-3530 ..... 186~~
~~8. Sanction Process ..... 187~~
~~9. Notice to CMS of Contractor Sanction ..... 188~~
~~10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures ..... 188~~
~~11. Contractor's Unit Responsible for Program Integrity Operations ..... 189~~
~~12. Contractor's Fraud, Waste, and Abuse Prevention Policies and Procedures ..... 190~~
~~13. Annual FWA Prevention Plan ..... 195~~
~~14. Review and Approval of Annual FWA Prevention Plan ..... 196~~
~~15. OHA and Contractor Program Integrity Audits of Network Providers ..... 197~~
~~16. Documenting and Processing Contractor Recovery of Overpayments Made to Third Parties ..... 199~~
~~17. Examples of Fraud, Waste, and Abuse ..... 200~~
~~18. Contractor's Obligations to Report Fraud, Waste and Abuse ..... 201~~
~~19. Assessment of Compliance Activities ..... 205~~
~~20. Additional OHA Provisions for Measuring Output and Reviewing Outcomes of Contractor's Program Integrity Operations ..... 207~~
~~**Exhibit B – Statement of Work – Part 10 – Transformation Reporting, Performance Measures and External Quality Review ..... 208**~~
~~1. Overview ..... 208~~
~~2. Quality Assessment and Performance Improvement Program and Quality Strategy Requirements 208~~
~~3. Performance Measures ..... 208~~
~~4. Performance Measures: Quality Pool Incentive Payments ..... 209~~
~~5. Performance Measure Incentive Payments for Participating Providers ..... 212~~
~~6. Performance Improvement Projects ..... 212~~
~~7. Additional Health System Transformation Obligations ..... 213~~
~~8. External Quality Review ..... 213~~
~~9. Excluded Populations ..... 214~~
~~**Exhibit C – Consideration ..... 215**~~
~~1. Payment Types and Rates ..... 215~~
~~2. Payment in Full ..... 220~~
~~3. Changes in Payment Rates ..... 220~~
~~4. Timing of CCO Payments ..... 222~~
~~5. Settlement of Accounts ..... 223~~
~~6. Risk Corridors ..... 225~~
~~7. Global Payment Rate Methodology ..... 234~~
~~8. Administrative Performance Penalty ..... 234~~
~~9. Quality Pool ..... 234~~
~~10. Minimum Medical Loss Ratio ..... 234~~

~~Exhibit D – Standard Terms and Conditions ..... 239~~
~~1. Governing Law, Consent to Jurisdiction ..... 239~~
~~2. Compliance with Applicable Law ..... 239~~
~~3. Independent Contractor ..... 240~~
~~4. Representations and Warranties ..... 240~~
~~5. Correction of Deficient Documents ..... 240~~
~~6. Funds Available and Authorized; Payments ..... 241~~
~~7. Recovery of Overpayments or Other Amounts Owed by Contractor ..... 241~~
~~8. Indemnity ..... 242~~
~~9. Default; Remedies; and Termination ..... 243~~
~~10. Effect of Legal Notice of Termination, Non-Renewal, or Failure to Renew: Transition Plan ..... 248~~
~~11. Effect of Termination or Expiration: Other Rights and Obligations ..... 250~~
~~12. Limitation of Liabilities ..... 252~~
~~13. Insurance ..... 252~~
~~14. Transparency: Public Posting of Contractor Reports; Public Records Requests ..... 252~~
~~15. Access to Records and Facilities; Records Retention; Information Sharing ..... 254~~
~~16. Force Majeure ..... 255~~
~~17. Foreign Contractor ..... 255~~
~~18. Assignment of Contract, Successors in Interest ..... 255~~
~~19. Subcontracts ..... 255~~
~~20. No Third Party Beneficiaries ..... 256~~
~~21. Amendments ..... 256~~
~~22. Waiver ..... 257~~
~~23. Severability ..... 257~~
~~24. Survival ..... 257~~
~~25. Legal Notice; Administrative Notice ..... 259~~
~~26. Construction ..... 260~~
~~27. Headings and Table of Contents ..... 260~~
~~28. Merger Clause ..... 260~~
~~29. Counterparts ..... 261~~
~~30. Equal Access ..... 261~~
~~31. Media Disclosure ..... 261~~
~~32. Mandatory Reporting of Abuse ..... 261~~
~~Exhibit E – Required Federal Terms and Conditions ..... 263~~
~~1. Miscellaneous Federal Provisions ..... 263~~
~~2. Equal Employment Opportunity ..... 263~~
~~3. Clean Air, Clean Water, EPA Regulations ..... 263~~
~~4. Energy Efficiency ..... 263~~
~~5. Truth in Lobbying ..... 264~~
~~6. HIPAA Compliance ..... 265~~
~~7. Resource Conservation and Recovery ..... 266~~
~~8. Audits ..... 266~~
~~9. Debarment and Suspension ..... 266~~
~~10. Pro-Children Act ..... 267~~
~~11. Additional Medicaid and CHIP Requirements ..... 267~~
~~12. Agency-based Voter Registration ..... 267~~
~~13. Clinical Laboratory Improvements ..... 267~~
~~14. Advance Directives ..... 268~~

15. Practitioner Incentive Plans 268
16. Risk HMO 268
17. Conflict of Interest Safeguards 268
18. Non-Discrimination 270
19. OASIS 270
20. Patient Rights Condition of Participation 270
21. Federal Grant Requirements 270
22. Mental Health Parity 271
23. Effect of Loss of Program Authority 272
24. ACA Section 1557 Coordinator 272

Exhibit F – Insurance Requirements 273

1. Workers' Compensation and Employers' Liability 273
2. Professional Liability 273
3. Commercial General Liability 273
4. Automobile Liability Insurance 273
5. Network Security and Privacy Liability 274
6. Excess/Umbrella Insurance 274
7. Additional Insured 274
8. Waiver of Subrogation 275
9. Continuous Claims Made Coverage 275
10. Notice of Change or Cancellation 275
11. Insurance Requirement Review 275
12. Certificate(s) and Proof of Insurance 275
13. State Acceptance 275
14. Self-insurance 276

Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy 277

1. Delivery System Network (DSN) Provider Monitoring and Reporting Overview 277
2. Delivery System Network Provider Monitoring and Reporting Requirements 277
3. Cooperative Agreements with Publicly Funded Programs 278
4. Cooperative Agreements with Community Social and Support Service and Long Term Care 279
5. Hospital Network Adequacy 279

Exhibit H – Value Based Payment 281

1. VBP Annual Requirement 281
2. Expanding VBP Beyond Primary Care to Other Care Delivery Areas 281
3. Patient-Centered Primary Care Home (PCPCH) VBP Requirements 281
4. VBP Targets by Year 282
5. VBP Data Reporting; Overview 282
6. VBP Data Reporting 283
7. Transparency and VBP Data 284

Exhibit I – Grievance and Appeal System 285

1. Grievance and Appeal System – Requirements 285
2. Grievances 287
3. Notice of Adverse Benefit Determination – Requirements 288
4. Handling of Appeals 291
5. Contested Case Hearings 294

~~6. Continuation of Benefits ..... 295~~
~~7. Implementation of Reversed Appeal Resolution ..... 296~~
~~8. Final Order on Contested Case Hearings ..... 296~~
~~9. Record Keeping and Quality Improvement ..... 296~~
~~10. Grievance and Appeal System, Policies and Procedures, and Member Notice Templates ..... 297~~

~~**Exhibit J – Health Information Technology ..... 300**~~

~~1. Health Information Technology Requirements ..... 300~~
~~2. Health Information Technology Roadmap ..... 301~~
~~3. Interoperability and Access to Health Information ..... 303~~

~~**Exhibit K – Social Determinants of Health and Equity ..... 305**~~

~~1. Community Advisory Council ..... 305~~
~~2. Community Advisory Council Membership ..... 305~~
~~3. Community Advisory Council Meetings ..... 306~~
~~4. Duties of the CAC ..... 307~~
~~5. [RESERVED] ..... 307~~
~~6. Community Health Assessment ..... 307~~
~~7. Community Health Improvement Plan ..... 310~~
~~8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE ..... 313~~
~~9. Flexible Services ..... 315~~
~~10. Health Equity Plan ..... 316~~
~~11. Traditional Health Workers ..... 317~~
~~12. REALD Data Collection ..... 321~~

~~**Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth ..... 322**~~

~~1. Overview of Solvency Plan ..... 322~~
~~2. Financial Responsibility; Allowable Expenses and Costs ..... 322~~
~~3. NAIC Financial Reporting ..... 324~~
~~4. Supplemental Financial Reporting ..... 326~~
~~5. Other Required Reports ..... 327~~
~~6. Assumption of Risk/Private Market Reinsurance ..... 327~~
~~7. Restricted Reserve Requirements ..... 328~~
~~8. Risk Based Capital and Capital Adequacy Requirements ..... 329~~
~~9. Sustainable Rate of Growth Requirement ..... 329~~
~~10. Delivery of Reports, Information, and Documents to OHA ..... 330~~

~~**Exhibit M – Behavioral Health ..... 331**~~

~~1. Behavioral Health Requirements ..... 331~~
~~2. Financial Matters Relating to Behavioral Health Services ..... 332~~
~~3. Integration, Transition, and Collaboration with Partners ..... 333~~
~~4. Policies and Procedures ..... 334~~
~~5. Referrals, Prior Authorizations, and Approvals ..... 334~~
~~6. Screening Members ..... 335~~
~~7. Substance Use Disorders ..... 335~~
~~8. Co-Occurring Disorders ..... 337~~
~~9. Gambling Disorders ..... 337~~
~~10. Assertive Community Treatment ..... 337~~
~~11. Peer Delivered Services and Outpatient Behavioral Health Services ..... 338~~
~~12. Behavioral Health Crisis Management System ..... 339~~

~~13. Care Coordination ..... 339~~
~~14. Community Partner Engagement ..... 340~~
~~15. Oregon State Hospital ..... 340~~
~~16. Emergency Department Utilization ..... 340~~
~~17. Involuntary Psychiatric Care ..... 341~~
~~18. Long Term Psychiatric Care ..... 341~~
~~19. Acute Inpatient Hospital Psychiatric Care ..... 343~~
~~20. Pregnant Individuals' Health ..... 344~~
~~21. Children and Youth Behavioral Health Services ..... 344~~
~~22. Intensive In-Home Behavioral Health Treatment ..... 349~~
~~23. Reporting Requirements ..... 349~~
~~24. Providers ..... 350~~
~~25. Mental Health Parity Reporting Requirements ..... 350~~
~~Exhibit N – Privacy and Security ..... 352~~
~~1. Purpose ..... 352~~
~~2. Definitions ..... 352~~
~~3. Changes to Form MSC 0785 ..... 353~~
~~4. Notifications ..... 353~~
~~5. Grant of License ..... 353~~
~~6. Data Privacy ..... 353~~
~~7. Security Requirements ..... 354~~
~~8. Access to OHA Systems ..... 355~~
~~9. Sanctions for Breach ..... 357~~
~~10. Survival ..... 357~~
~~11. Costs ..... 357~~
~~12. Interpretation ..... 357~~
~~13. Subcontractors ..... 357~~
~~General Provisions – Attachment 1 ..... 358~~
~~Exhibit C – Attachment 1 ..... 375~~
~~Exhibit D – Attachment 1 ..... 376~~
General Provisions 16
1. Annual Approval; Duration of Contract 16
2. Contract Administrators 17
3. Enrollment Limits and Service Area 17
4. Entire Contract; Administration of Contract; Interpretation of Contract 18
5. Contractor Data and Certification 21
Exhibit A – Definitions 24
Exhibit B – Statement of Work – Part 1 – Governance and Organizational Relationships 59
1. Governing Board and Governance Structure 59
2. Clinical Advisory Panel 59
3. Tribal Liaison 59
4. Innovator Agent and Learning Collaborative 60
Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services 62
1. Covered Services 62

2. Provision of Covered Services 62
3. Authorization or Denial of Covered Services 65
4. Covered Service Component: Crisis, Urgent and Emergency Services 69
5. Covered Service Component: Non-Emergent Medical Transportation (NEMT) 70
6. Covered Service Components: Preventive Care, Family Planning, Sterilizations & Hysterectomies and Post Hospital Extended Care 80
7. Covered Service Component: Medication Management 82
8. Covered Service Components: Other Services 86
9. Non-Covered Health Services with Care Coordination 87
10. Non-Covered Health Services without Care Coordination 89
11. In Lieu of Services (ILOS) 90
12. Family Connects Oregon 96
13. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 97
14. Healthier Oregon Program 98
15. Health-Related Social Needs Services: Member Identification, Screenings, Authorizations, Denials, and Notifications 99
16. Health-Related Social Needs Services: Administrative and Delivery Processes; HRSN Service Delivery Network Requirements 108
17. OHP Bridge - Basic Medicaid Program 119
18. Reentry Health Care Services 119

Exhibit B – Statement of Work – Part 3 – Patient Rights and Responsibilities, Engagement and Choice 123

1. Member and Member Representative Engagement in Member Health Care and Treatment Plans . 123
2. Member Rights and Responsibilities under Medicaid 123
3. Provider's Opinion 127
4. Informational Materials for Members and Potential Members: General Information and Education 127
5. Informational Materials for Members and Potential Members: Member Handbook 130
6. Informational Materials for Members and Potential Members: Provider Directory 131
7. Grievance and Appeal System 133
8. Enrollment 133
9. Disenrollment 134
10. Member Benefit Package Changes 135
11. Enrollment Reconciliation 135
12. Identification Cards 136
13. Marketing to Potential Members 136

Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems 138

1. Integration and Coordination 138
2. Access to Care 139
3. Delivery System and Provider Capacity 144
4. Provider Selection 146
5. Credentialing 147
6. Patient Centered Primary Care Homes 149
7. Indian Health Care Providers 150
8. Care Coordination 150
9. Care Integration 151
10. Delivery System Dependencies 152

11. Evidence-Based Clinical Practice Guidelines 153
12. Subcontract Requirements 153
13. Minority-Owned, Woman-Owned and Emerging Small Business Participation 160
14. Adjustments in Service Area or Enrollment 161
[Exhibit B, Parts 5 through 7 are reserved.] 164
Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations 165
1. Record Keeping Requirements 165
2. Privacy, Security, and Retention of Records; Breach Notification 166
3. Access to Records 167
4. Payment Procedures 167
5. Claims Payment 168
6. Medicare Payers and Providers 171
7. Eligibility Verification for Fully Dual Eligible Members 172
8. All Payer All Claims Reporting Program 173
9. Cost Growth Target Program 173
10. Health Care Market Oversight Program 173
11. Administrative Performance Program: Valid Encounter Claims Data 173
12. Encounter Data Submission Processes 175
13. Additional Encounter Data Submission Requirements: Non-Pharmacy Encounter Data 176
14. Pharmacy Encounter Data 176
15. Administrative Performance Standard 177
16. Drug Rebate Program 178
17. Drug Rebate Dispute Resolution Process 179
18. Third Party Liability, Excluding Personal Injury Liens 179
19. Personal Injury Liens 182
20. Disclosure of Ownership Interests 185
21. Disclosure of Other Ownership Interests 187
22. Certain Changes in Control Requiring Pre-Approval from OHA 187
23. Subrogation 189
24. Contractor's Governing Board 189
Exhibit B – Statement of Work – Part 9 – Program Integrity 190
1. Monitoring and Compliance Review - Overview 190
2. Conditions That May Result in Sanctions 190
3. Range of Sanctions Available 192
4. Amount of Civil Money Penalties: 42 CFR § 438.704 193
5. Temporary Management 194
6. Corrective Action Plan 195
7. Civil Money Penalties: OAR 410-141-3530 195
8. Sanction Process 196
9. Notice to CMS of Contractor Sanction 197
10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures 197
11. Contractor's Unit Responsible for Program Integrity Operations 198
12. Contractor's Fraud, Waste, and Abuse Prevention Policies and Procedures 199
13. Annual FWA Prevention Plan 204
14. Review and Approval of Annual FWA Prevention Plan 205
15. OHA and Contractor Program Integrity Audits of Network Providers 206

16. Documenting and Processing Contractor Recovery of Overpayments Made to Third Parties 208
17. Examples of Fraud, Waste, and Abuse 209
18. Contractor's Obligations to Report Fraud, Waste and Abuse 210
19. Assessment of Compliance Activities 214
20. Additional OHA Provisions for Measuring Output and Reviewing Outcomes of Contractor's Program Integrity Operations 216

Exhibit B – Statement of Work – Part 10 – Transformation Reporting, Performance Measures and External Quality Review 217

1. Overview 217
2. Quality Assessment and Performance Improvement Program and Quality Strategy Requirements 217
3. Performance Measures 217
4. Performance Measures: Quality Pool Incentive Payments 218
5. Performance Measure Incentive Payments for Participating Providers 221
6. Performance Improvement Projects 221
7. Additional Health System Transformation Obligations 222
8. External Quality Review 222
9. Excluded Populations 223

Exhibit C – Consideration 224

1. Payment Types and Rates 224
2. Payment in Full 229
3. Changes in Payment Rates 229
4. Timing of CCO Payments 231
5. Settlement of Accounts 232
6. Risk Corridors 234
7. Global Payment Rate Methodology 243
8. Administrative Performance Penalty 243
9. Quality Pool 244
10. Minimum Medical Loss Ratio 244

Exhibit D – Standard Terms and Conditions 248

1. Governing Law, Consent to Jurisdiction 248
2. Compliance with Applicable Law 248
3. Independent Contractor 249
4. Representations and Warranties 249
5. Correction of Deficient Documents 249
6. Funds Available and Authorized; Payments 250
7. Recovery of Overpayments or Other Amounts Owed by Contractor 250
8. Indemnity 251
9. Default; Remedies; and Termination 252
10. Effect of Legal Notice of Termination, Non-Renewal, or Failure to Renew: Transition Plan 257
11. Effect of Termination or Expiration: Other Rights and Obligations 259
12. Limitation of Liabilities 261
13. Insurance 261
14. Transparency: Public Posting of Contractor Reports; Public Records Requests 261
15. Access to Records and Facilities; Records Retention; Information Sharing 263
16. Force Majeure 264
17. Foreign Contractor 264
18. Assignment of Contract, Successors in Interest 264

19. Subcontracts 264
20. No Third Party Beneficiaries 265
21. Amendments 265
22. Waiver 266
23. Severability 266
24. Survival 266
25. Legal Notice; Administrative Notice 268
26. Construction 269
27. Headings and Table of Contents 269
28. Merger Clause 269
29. Counterparts 270
30. Equal Access 270
31. Media Disclosure 270
32. Mandatory Reporting of Abuse 270

Exhibit E – Required Federal Terms and Conditions 272

1. Miscellaneous Federal Provisions 272
2. Equal Employment Opportunity 272
3. Clean Air, Clean Water, EPA Regulations 272
4. Energy Efficiency 272
5. Truth in Lobbying 273
6. HIPAA Compliance 274
7. Resource Conservation and Recovery 275
8. Audits 275
9. Debarment and Suspension 275
10. Pro-Children Act 276
11. Additional Medicaid and CHIP Requirements 276
12. Agency-based Voter Registration 276
13. Clinical Laboratory Improvements 276
14. Advance Directives 277
15. Practitioner Incentive Plans 277
16. Risk HMO 277
17. Conflict of Interest Safeguards 277
18. Non-Discrimination 279
19. OASIS 279
20. Patient Rights Condition of Participation 279
21. Federal Grant Requirements 279
22. Mental Health Parity 280
23. Effect of Loss of Program Authority 281
24. ACA Section 1557 Coordinator 281

Exhibit F – Insurance Requirements 282

1. Workers' Compensation and Employers' Liability 282
2. Professional Liability 282
3. Commercial General Liability 282
4. Automobile Liability Insurance 282
5. Network Security and Privacy Liability 283
6. Excess/Umbrella Insurance 283
7. Additional Insured 283

8. Waiver of Subrogation 284
9. Continuous Claims Made Coverage 284
10. Notice of Change or Cancellation 284
11. Insurance Requirement Review 284
12. Certificate(s) and Proof of Insurance 284
13. State Acceptance 284
14. Self-insurance 285

Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy 286

1. Delivery System Network (DSN) Provider Monitoring and Reporting Overview 286
2. Delivery System Network Provider Monitoring and Reporting Requirements 286
3. Cooperative Agreements with Publicly Funded Programs 287
4. Cooperative Agreements with Community Social and Support Service and Long Term Care 288
5. Hospital Network Adequacy 288

Exhibit H – Value Based Payment 290

1. VBP Annual Requirement 290
2. Expanding VBP Beyond Primary Care to Other Care Delivery Areas 290
3. Patient-Centered Primary Care Home (PCPCH) VBP Requirements 290
4. VBP Targets by Year 291
5. VBP Data Reporting; Overview 291
6. VBP Data Reporting 292
7. Transparency and VBP Data 293

Exhibit I – Grievance and Appeal System 294

1. Grievance and Appeal System – Requirements 294
2. Grievances 296
3. Notice of Adverse Benefit Determination – Requirements 297
4. Handling of Appeals 300
5. Contested Case Hearings 303
6. Continuation of Benefits 304
7. Implementation of Reversed Appeal Resolution 305
8. Final Order on Contested Case Hearings 305
9. Record Keeping and Quality Improvement 305
10. Grievance and Appeal System, Policies and Procedures, and Member Notice Templates 306

Exhibit J – Health Information Technology 309

1. Health Information Technology Requirements 309
2. Health Information Technology Roadmap 310
3. Interoperability and Access to Health Information 312

Exhibit K – Social Determinants of Health and Equity 314

1. Community Advisory Council 314
2. Community Advisory Council Membership 314
3. Community Advisory Council Meetings 315
4. Duties of the CAC 316
5. [RESERVED] 316
6. Community Health Assessment 316
7. Community Health Improvement Plan 319
8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE 322

9. Flexible Services 324
10. Health Equity Plan 325
11. Traditional Health Workers 326
12. REALD Data Collection 330
Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth 331
1. Overview of Solvency Plan 331
2. Financial Responsibility; Allowable Expenses and Costs 331
3. NAIC Financial Reporting 333
4. Supplemental Financial Reporting 335
5. Other Required Reports 336
6. Assumption of Risk/Private Market Reinsurance 336
7. Restricted Reserve Requirements 337
8. Risk Based Capital and Capital Adequacy Requirements 338
9. Sustainable Rate of Growth Requirement 338
10. Delivery of Reports, Information, and Documents to OHA 339
Exhibit M – Behavioral Health 340
1. Behavioral Health Requirements 340
2. Financial Matters Relating to Behavioral Health Services 341
3. Integration, Transition, and Collaboration with Partners 342
4. Policies and Procedures 343
5. Referrals, Prior Authorizations, and Approvals 343
6. Screening Members 344
7. Substance Use Disorders 344
8. Co-Occurring Disorders 346
9. Gambling Disorders 346
10. Assertive Community Treatment 346
11. Peer Delivered Services and Outpatient Behavioral Health Services 347
12. Behavioral Health Crisis Management System 348
13. Care Coordination 348
14. Community Partner Engagement 349
15. Oregon State Hospital 349
16. Emergency Department Utilization 349
17. Involuntary Psychiatric Care 350
18. Long Term Psychiatric Care 350
19. Acute Inpatient Hospital Psychiatric Care 352
20. Pregnant Individuals' Health 353
21. Children and Youth Behavioral Health Services 353
22. Intensive In-Home Behavioral Health Treatment 358
23. Reporting Requirements 358
24. Providers 359
25. Mental Health Parity Reporting Requirements 359
Exhibit N – Privacy and Security 361
1. Purpose 361
2. Definitions 361
3. Changes to Form MSC 0785 362
4. Notifications 362
5. Grant of License 362

6. Data Privacy 362
7. Security Requirements 363
8. Access to OHA Systems 364
9. Sanctions for Breach 366
10. Survival 366
11. Costs 366
12. Interpretation 366
13. Subcontractors 366
General Provisions – Attachment 1 367
Exhibit C – Attachment 1 384
Exhibit D – Attachment 1 385

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

OREGON HEALTH PLAN

HEALTH PLAN SERVICES CONTRACT

COORDINATED CARE ORGANIZATION

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

«Registered_Name» «Registered_ABN», an Oregon «Entity_Type»,
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, 2026 ("2026 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 2026 A&R Effective Date.

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

Medicaid Division
500 Summer Street NE, E35
Salem, Oregon 97301

General Provisions

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 2026 CCO Payment Rates prior to the 2026 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 nine (9) years from its coverage effective date of January 1, 2020, unless terminated earlier as provided for in this Contract. This nine-year Term reflects the following: (i) the original five-year Term of the Contract; (ii) the two-year extension pursuant to Section 2, Chapter 441, Oregon Laws 2023; and (iii) the additional two-year extension pursuant to OHA's exercise of its authority provided in Section 2 of Enrolled Oregon House Bill 2205 (2025). This 2026 amended and restated Contract is Contract Year seven of the nine-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,[1] and OAR 410-141-3725, to Renew this Contract for up to two additional, successive Contract Years following Contract Year seven. 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, 2028. 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 Renewal Contract 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»
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 Medicaid Division
500 Summer Street NE, E35
Salem, OR 97301
Phone: 503-593-6894
Email: Cheryl.L.Henning@oha.oregon.gov

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

[1] This existing OAR will be updated effective 1/1/2026.

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 Ex. B, Part 3, Sec. 8 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 Secs. 1 through 5 (the "General Provisions"), together with the following Exhibits and Exhibit attachments, and Reference Documents described in Sec. 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 N:	Privacy and Security

*Exhibit C-Attachment 1 (CCO Payment Rates) and **Exhibit D-Attachment 1 (Deliverables and Required Notices) are attached after Ex. N.

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 "Delegation Authorization and Signature Form" available on the CCO Contract Forms Website. Contractor shall submit the completed form to OHA, via Administrative Notice, to add or remove an employee with delegated authority and to change the name, contact information, or submission type(s) authorized for a delegated employee.

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

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. For convenience, OHA has provided in Attachment 1 to these General Provisions the permanent URL for each Oregon Administrative Rule (OAR) and OAR Chapter and Division referenced in this Contract, organized by exhibit, and sorted numerically.

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.

4.3.1. To the extent provisions contained in more than one of the documents listed in Sec. 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 order of precedence set forth in Sections 4.3.1.1 and 4.3.1.2 only in the event of an irreconcilable conflict. And, in such event, the conflict will be resolved by considering the version(s) of the provision(s) that was in effect when the applicable event, obligation, or action occurred.

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 Condition
ii.	Exhibit N:	Privacy and Security
iii.	Exhibit A:	Definitions
iv.	Exhibit B:	Statement of Work
v.	Exhibit D:	Standard Terms and Conditions
vi.	Exhibit C:	Consideration
vii.	Exhibit L:	Solvency Plan, Financial Reporting, and Sustainable Rate of Growth
viii.	Exhibit I:	Grievance and Appeal System
ix.	Exhibit G:	Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy
x.	Exhibit M:	Behavioral Health
xi.	Exhibit K:	Social Determinants of Health and Equity
xii.	Exhibit J:	Health Information Technology
xiii.	Exhibit H:	Value Based Payment
xiv.	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 Ex. B, Part 1 and the CHP Progress Report Guidance template, which is first referenced in Ex. N, the apparent conflicting provision in Ex. 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 Ex. 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 Ex. N shall take precedence.

4.3.2. In the event that the Parties need to look outside of this Contract in order to interpret its terms, the Parties shall follow the order of precedence set forth in OAR 410-141-3501(2). 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.

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.

[Remainder of page intentionally left blank]

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 Ex. 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. 14.

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 _____

Federal Employer Identification Number (FEIN) _____

Is Contractor a nonresident alien, as defined in 26 U.S.C. § 7701(b)(1)? ☐ 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 Co. _____

Policy # _____ Expiration Date _____

Commercial General Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Automobile Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Network Security & Privacy Liability Insurance Co. _____

Policy # _____ Expiration Date _____

Workers' Compensation: Does Contractor have any subject workers, as defined in ORS 656.027?

☐ **YES** ☐ **NO** If Yes, provide the following information:

Workers' Compensation Insurance Co. _____

Policy # _____ Expiration Date _____

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

Form of Legal Entity: (mark 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. Contractor acknowledges 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. Contractor certifies that no claim (described in Sec. 5.1.1 above) that has been or will be submitted by Contractor under this Contract is or will be a "False Claim" (as defined by ORS 180.750). Contractor further certifies that Contractor has not and will not take any action under this Contract that is 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 Sec. 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:

5.1.9.1. Contractor is exempt from backup withholding;

5.1.9.2. 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

5.1.9.3. 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 Sec. 5 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 Medicaid Division CCO Operations Unit
By:

David Inbody, CCO Operations Director	Date

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

Emma Sandoe, PhD, Medicaid Director	Date

Approved as to Legal Sufficiency:

Electronic approval by Ellen D. Taussig Conaty, Senior Assistant Attorney General, Health and Human Services Section, on October ~~xx, xxxx~~30, 2025; 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):

a. Express definitions in Ex. A,

b. Express definitions elsewhere in this Contract,

c. Definitions in the OARs cited in Ex. A, and

d. Definitions in OARs not specifically cited in Ex. 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.

"2023 Federal Consolidated Appropriations Act" and **"FCAA"** each means the federal spending law (P.L. 117-328) that requires in relevant part, specific Reentry FCAA Services to be provided to FCAA-Covered Youth.[2]

[2] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

"2026 A&R Effective Date" means the date on which this Contract became effective, as amended and restated for Contract Year seven, which is January 1, 2026.

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

"Abuse of Child In Care" means abuse of a child as the terms abuse and child in care are defined under ORS 418.257.

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

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

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

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

"Adjudication" has the meaning provided in OAR 410-141-3500. For a final MCE claims decision, the date of "Adjudication" is the date on which the CCO 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 Sec. 25, Para. b. of Ex. 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 Ex. C, Sec. 4 that will be withheld during the Withhold Month.

"Adult Abuse" means abuse of an adult as the terms abuse and adult are defined under ORS 430.735.

"Adults and Youths Discharged from an HRSN Eligible Behavioral Health Facility" has the meaning provided for in OAR 410-120-0000 and includes the following facilities:

- **a.** Acute Care Psychiatric Hospitals as defined in OAR 309-015-0005,
- **b.** Institution for Mental Diseases as defined in 42 CFR 435.1010,
- **c.** Integrated Psychiatric Residential Treatment Facilities and Residential Substance Use Disorders Treatment Program as defined in OAR 309-022-0105,
- **d.** Residential Treatment Facilities (RTF) as defined in OAR 309-035-0105,
- **e.** Residential Treatment Homes (RTH) as defined in OAR 309-035-0105,
- **f.** Secure Residential Treatment Facilities (SRTF), as defined in OAR 309-035-0105,
- **g.** Psychiatric Residential Treatment Facilities (PRTF) as defined in OAR 309-022-0105, and
- **h.** Residential Substance Use Disorders Treatment Program as defined in OAR 309-018-0105.

"Adults and Youths Released from Incarceration" has the meaning provided for in OAR 410-120-0000.

"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, generally, 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. The term **"Affiliate"** has different meanings in different contexts as governed by the applicable Oregon Administrative Rule. For example, the term **"Affiliate"** has a specific meaning under OAR 410-141-3735 as it relates to SDOH and SHARE and another meaning under OAR 410-141-5285 as it relates to financial control and transactions related to the business operations of Contractor. See also the definitions of "Control" as defined below in this Exhibit A and under OARs 410-141-3735 and 410-141-5285.

"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 8, Sec. 10, 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 has the meaning provided for in OAR 410-141-3500. **"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 FWA Referrals and Investigations Report" means that annual Fraud, Waste, and Abuse referrals and investigations Report required to be provided to OHA in accordance with Ex. B, Part 9 to this Contract.

"AP Standard" means the standard for accurate and timely submission of all Valid Claims for a Subject Month within forty-five (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 Ex. C, Sec. 4 that will be withheld during the Withhold Month.

"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.

"ASAM" means the American Society of Addiction Medicine.

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

"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.

"Attestation" means an attestation made on the attestation form located on the CCO Contract Forms Website, signed by Contractor's Chief Executive Officer (CEO) or Chief Financial Officer (CFO) 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.

"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" and **"BRS"** each means the services provided through the Behavior Rehabilitation Services Program defined in OAR Chapter 410, Division 170.

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

"Behavioral Health Coverage" means Mental Health Treatment and Services and Substance Use Disorder Treatment and Services covered under this Contract.

"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.

"Behavioral Health Resource Network" has the meaning provided for in OAR 944-001-0010.

"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.

"Care Coordination" has the meaning provided for in OAR 140-141-3500.

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

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

"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.

"Certified Recovery Mentor" has the meaning provided for in OAR 309-083-0010.

"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" means 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.

"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.

"Clean Claim" has the meaning provided for in 42 CFR 447.45(b)**.**

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

"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 ~~HosFpital~~Hospital Psychiatric Care stay.

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

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

"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~~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.

"CMS Interoperability and Prior Authorization Final Rule" means the CMS Interoperability and Prior Authorization Final Rule that was published in the Federal Register with the heading "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program" in Volume 89, No. 27, 8758 through 8988, February 8, 2024. The CMS Interoperability and Prior Authorization Final Rule became effective on April 8, 2024, and served to amend a number of regulations within 42 CFR Parts 422, 431, 435, 438, 440, and 457. All of the specific amended regulations can be found in, without having to search for them within the Code of Federal Regulations, the Federal Register in which they were published which is located at the following URL: https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

"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 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 Information Exchange" and **"CIE"** each 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 CCOs 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 Ex. B, Part 8, Sec. 10 of this Contract.

"Complex Rehabilitation Technology" has the meaning provided for in Section 2 of Enrolled Oregon Senate Bill 549 (2025).

"Condition/Treatment Pair" has the meaning provided for in OAR 410-120-0000.

"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 Sec. 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 Sec. 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, generally, 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. See also the definitions of "Control" under OARs 410-141-3735 and 410-141-5285

"Co-Occurring Disorder" means the occurrence in an individual of:

a. Two or more Behavioral Health disorders, including a mental health disorder and either a Substance Use Disorder or problem gambling; or

b. A Behavioral Health disorder and an intellectual/developmental disability.

"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.

"Correctional Facility" means, for the purpose of Reentry FCAA Services required to be provided under this Contract, state prisons, county or regional jails, tribal jails and prisons, juvenile detention, or state youth correctional ~~facility~~facilities.[3]

"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 410-141-3820.

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

"Credibility Adjustment" means an adjustment to the MLR for a partially credible CCO to account for a difference between the actual and target MLRs that may be due to random statistical variation.

"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 Services" 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. "Culturally and

[3] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

Linguistically Appropriate Services" includes meaningful language access as required by Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services.

"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.

"Delivery System Network" and **"DSN"** each has the meaning provided for in OAR 410-141-3500. **"Provider Network"** has the same meaning.

"Demographic Data" has the meaning provided for in OAR 950-030-0010.[4]

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

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

"Dental Subcontractor" has the meaning provided for in OAR 410-120-0000.[5]

"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.

"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.

"Doula" has the meaning provided for in Enrolled Oregon Senate Bill 692 (2025). A Doula is distinguished as a **"Birth Doula"** or a **"Postpartum Doula"** based on the qualifications specified in OAR 950-060-0010.[6]

"Downstream Entity" means any party that enters into a written or oral contract or other agreement with a CCO's Subcontractor pursuant to which such party performs one or more of the obligations of the Subcontractor under the Subcontractor's Subcontract with the CCO. Regardless of the number of parties that are downstream from a CCO's Subcontractor, a party is deemed a "Downstream Entity" of a CCO Subcontractor if such party is, pursuant to a written or oral contract or agreement, performing the obligations the Subcontractor is required to perform on behalf of the CCO under its Subcontract therewith.

"Drug Utilization Review Program" and **"DUR Program"** each means the drug utilization review program that complies with 42 CFR Part 456, Subpart K.

[4] This existing OAR will be updated effective 1/1/2026.
[5] This existing OAR will be updated effective 1/1/2026.
[6] This existing OAR will be updated effective 1/1/2026 to reflect the two different types of Doulas.

"Dual Special Needs Plan" and **"DSNP"** each means a specific type of Medicare Advantage Plan for those individuals who are dual eligible 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.

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

"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 and Periodic Screening, Diagnostic, and Treatment" and **"EPSDT"** each has the meaning provided for in OAR 410-120-0000.

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

"Emergency Health Benefit Funding" has the meaning provided for in OAR 410-120-0000. In some instances, Emergency Health Benefit Funding may be referred to as "EHB" in this Contract.

"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 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; (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.

"Enhanced Care Outreach Services" has the meaning provided for in OAR 309-019-0105.

"Enhanced Care Services" has the meaning provided for in OAR 309-019-0105.

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

"EPSDT Medically Appropriate" has the meaning provided for in OAR 410-151-0001.

"EPSDT Medically Necessary" has the meaning provided for in OAR 410-151-0001.

"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, 2028, as identified in Sec. 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 Connects Oregon" and **"FCO"** each means the voluntary, universally offered newborn nurse home visiting program established by ORS 433.301.

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

"Family Support Specialist" has the meaning provided for in OAR 950-060-0010.

"FCAA-Covered Youth" means Medicaid or CHIP-enrolled youth who are either (i) under age 21 or (ii) determined eligible for the mandatory former foster care Medicaid eligibility group, as described in OAR 410-200-0407, and are held in a correctional facility post-adjudication. All FCAA-Covered Youth are Members.[7]

"Federal Indian Trust Responsibility" and **"Trust Responsibility"** each means a legal obligation under which the United States "has charged itself with moral obligations of the highest responsibility and trust" toward Indian tribes. It is also a legally enforceable fiduciary obligation on the part of the United States to protect tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of federal law with respect to Federally Recognized Tribes. *See Seminole Nation v. United States*, 316 U.S. 286 (1942).

"Federal Medical Loss Ratio" and **"Federal MLR"** each means the proportion of adjusted premium revenue spent on incurred claims or other eligible expenses as defined in 42 CFR § 438.8, together with any supplementary guidance provided by CMS.

"Federally Qualified Health Center" and **"FQHC"** each has the meaning provided for in OAR 410-120-0000.

"Federally Recognized Tribe" means an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs.

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

[7] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

"Fee-for-Service Equivalent Value" means the amount Contractor would reimburse a Provider on a claim for healthcare services on a Fee-For-Service (FFS) basis in the absence of a Value Based Payment Arrangement.

"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:

a. adherence to the core values and principles of Wraparound care planning processes and supports;

b. whether the basic activities of facilitating a Wraparound process are occurring; and

c. 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" has the meaning provided for in OAR 410-141-3500 and the requirements related to the implementation and administration of a Flexible Service are described in OAR 410-141-3845.[8]

"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).

"Fruit and Vegetable Benefit" has the meaning provided in OAR 410-120-0000.

"Full Credibility" means the experience of a CCO is determined, under CMS guidance[9], to be sufficient, measured in terms of member months, for the calculation of a MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. A CCO that is assigned Full Credibility (or is Fully Credible) will not receive a credibility adjustment to its MLR.

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

"Full Time Employee" and **"FTE Employee"** each means a person who is employed not less than thirty-six (36) hours in any one calendar week.

"FWA Prevention Handbook" means the handbook of Fraud, Waste, and Abuse policies and procedures that complies with the requirements set forth in Sec. 12 of Ex. B, Part 9 and any other applicable provisions of this Contract.

"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

[8] This change reflect OHA's intention to change the name "Health-Related Services" to "Flexible Services" through proposed OARs effective 1/1/2026.
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf

"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.

"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 developed and implemented by Contractor 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:

- **a.** enables care coordination among Providers,
- **b.** contains costs through the sharing of medical information useful in diagnosis and treatment decision making,
- **c.** facilitates patient registries,
- **d.** enables unified quality reporting, and
- **e.** 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-Related Social Needs" and **"HRSN"** each has the meaning provided for in OAR 410-120-0000.

"Health Risk Assessment" has the meaning provided for in OAR 410-141-3500.

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

"Healthier Oregon Program Members" means some or all of the individuals enrolled under the Healthier Oregon Program (HOP) rate groups identified in the CCO Payment Rates provided in Exhibit C-Attachment 1 of this Contract.

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

"HIT Commons" means the shared public/private governance body 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**")/Collective Platform (formerly known as 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.

"Home Changes for Health During Extreme Weather" and **"Home Changes for Health"** each means the devices and services provided to HRSN-Authorized Members for whom such equipment and support are Clinically Appropriate as a component of health services treatment or prevention as detailed in OAR 410-120-2005.[10]

a. Clinically Appropriate devices include:

(i) Air conditioners for individuals at health risk due to significant heat;

(ii) Heaters for individuals at increased health risk due to significant cold;

(iii) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;

(iv) Mini refrigeration units as needed for individuals for medication storage; and

(v) Portable power supplies (PPSs) for individuals who need access to electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that may compromise their ability to use medically necessary devices.

b. Services include, as may be needed by the Member, the provision and service delivery, and, as needed, installation of all the devices (identified in (i)-(v) above) and device maintenance.

"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

[10] This existing OAR will be updated effective 1/1/2026.

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 Ex. 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).

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

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

"HRSN Clinical Risk Factor" has the meaning provided for in OAR 410-120-0000.

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

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

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

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

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

"HRSN Home Changes for Health During Extreme Weather Device Clinical Risk Factor" has the meaning provided for in OAR 410-120-0000.

"HRSN Outreach and Engagement Services" has the meaning provided for in OAR 410-120-0000.

"HRSN Person-Centered Service Plan" and **"HRSN PCSP"** each has the meaning provided for in OAR 410-120-0000 and must be incorporated as a component of the Member's Care Plan as defined at OAR 410-141-3870.

"HRSN Self-Attestation" and **"Self-Attestation"** each has the meaning provided for in OAR 410-120-0000.

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

"HRSN Service Request" and **"HRSN Request"** each has the meaning provided for in OAR 410-120-0000.

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

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

"HRSN Social Risk Factor" has the meaning provided for in OAR 410-120-0000.

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

"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.

"In Lieu of Service" and **"ILOS"** each has the meaning provided for in OAR 410-141-3500.

"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 meaning provided for in OAR 410-141-3500. **"American Indian/Alaska Native"** and **"AI/AN"** each has the same meaning.

"Indian Health Care Delivery System" means the system which includes (i) Indian Health Service (IHS) facilities, (ii) Tribal 638 programs authorized under the Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) as amended from time to time and the implementing federal regulations found in 25 CFR Part 900 and 42 CFR Part 137, and (iii) Urban Indian Organizations as such term is defined under 25 USC §1603(29).

"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 Flexible 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:

- **a.** Identification of the Medicaid and non-Medicaid services necessary to effectively address the needs of the IMP Member;
- **b.** A plan for providing the necessary Medicaid and non-Medicaid services to the IMP Member;
- **c.** Identification of the IMP Member's housing needs;
- **d.** 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
- **e.** 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 Flexible 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.

"Individuals Involved with Child Welfare" has the meaning provided for in OAR 410-120-0000.

"Individuals Transitioning to Dual Status" has the meaning provided for in OAR 410-120-0000.

"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.

"Institution for Mental Diseases" and **"IMD"** each has the meaning provided for 42 CFR § 435.1010.

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

"Intensive Outpatient Services and Supports" and **"IOSS"** each has the meaning provided for in OAR 309-019-0105.

"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 Ex. 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.

"Lactation Counselor" has the meaning provided for in Section 12 of Enrolled Oregon Senate Bill 692 (2025).

"Lactation Educator" has the meaning provided for in Section 12 of Enrolled Oregon Senate Bill 692 (2025).

"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:

- **a.** information about Quality Improvement;
- **b.** best practices about methods to change payment to pay for quality and performance;
- **c.** best practices and emerging practices that increase access to Culturally and Linguistically Appropriate care and reduce health disparities;
- **d.** best practices that increase the adoption and use of the latest techniques in effective and Cost Effective patient centered care;
- **e.** information to coordinate efforts to develop and test methods to align financial incentives to support PCPCHs;
- **f.** best practices for maximizing the utilization of PCPCHs by individuals enrolled in Medical Assistance Programs, including culturally specific and targeted Outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;
- **g.** best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventive and disease management services;
- **h.** information and best practices on the use of Flexible Services; and
- **i.** 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 Ex. D, Sec. 25, Para. a. of this Contract.

"LGBTQIA2S+" is an acronym for Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, Two-Spirit, and the countless affirmative ways in which people choose to self-identify on the gender expansive and sexual identity spectrums.

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

"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 309-019-0105.

"Lien Release Template" means that lien release template Contractor is required to create under Ex. B, Part 8, Sec. 19, Para. k of this 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 has the meaning provided for in ORS 430.630(9).

"Local Planning Committee" has the meaning provided for in ORS 430.306.

"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.

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

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

"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.

"Material Change to Delivery System" has the meaning provided for in OAR 410-141-3500.

"Measurement Year" means the preceding calendar year.

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

"Medicaid Contract" and **"Medicaid Services Contract"** each means this Contract, inclusive of both the Medicaid program and the Children's Health Insurance Program.

"**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" or **"MLR"** used without specific reference to Federal MLR or Oregon MLR means either Federal MLR or Oregon MLR.

"MLR Community Rebate" means the expenditure by Contractor of an amount less than or equal to its MMLR Rebate on an OHA-approved activity or initiative to improve health equity or public health. The approved activities and initiatives and other information relating to the MLR Community Rebate will be described in an associated Guidance Document.

"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.

"Medically Tailored Meals" 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 has the meaning provided for in OAR 309-019-0105.

"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, Ex. B, Part 3, and which is provided to Contractor's Members in accordance therewith.

"Member Representative" has the meaning provided for in OAR 410-141-3500. A Member Representative may be, in the following order of priority:

- **a.** 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),
- **b.** a spouse, or other Family member as designated by the Member, the Individual Service Plan Team (for Members with developmental disabilities),
- **c.** a parent or legal guardian of a minor below the age of consent,
- **d.** an DHS or OHA case manager or other ODHS or OHA designee. For Members in the care or custody of ODHS Children, Adults, and Families (CAF) or OYA, the Member Representative is ODHS or OYA. For Members placed by ODHS 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.

"Mental Health Treatment and Services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the (i) International Classification of Disease or (ii) Diagnostic and Statistical Manual of Mental Disorders.

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

"Minimum Medical Loss Ratio" and **"MMLR"** each means the minimum Oregon MLR required to be met by Contractor in accordance with the terms and conditions of this Contract.

"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 Rebate Period" means each Contract Year, effective beginning with Contract Year five (2024).

"MMLR Rebate Report" means Contractor's Report of financial information required for calculating MMLR, included in the Minimum Medical Loss Ratio Rebate Calculation template (Excel Workbook).

"MMLR Standard" means, for Contract Year seven (2026), the MMLR for Contractor's total Member population where the specific MMLR varies based on the Tier to which a CCO is categorized in the Actuarial Report titled "Oregon CY26 Rate Certification – CCO Rates" available at https://www.oregon.gov/oha/fod/pages/ohp-rates.aspx and where the use of the term "Tier" in this context is explained in such Actuarial Report. For a CCO categorized as Tier 1, the MMLR is eighty-seven percent (87%). For a CCO categorized as Tier 2 or Tier 3, the MMLR is eighty-six (86%). Contractor is categorized as Tier

[insert CCO-specific #].«M_2026_Tiers_for_MMLR_and_HRSN». The MMLR Standard includes the portion of the HOP benefit package paid under this Contract with Emergency Health Benefit Funding.

"MMLR Template" means the Minimum Medical Loss Ratio Rebate Calculation template (Excel Workbook) located on the CCO Contract Forms Website.

"Mobile Crisis Intervention Services" and **"MCIS"** each has the meaning provided for in OAR 309-072-0110.

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

"Monitor" means:

- **a.** to observe and check the progress or quality of something,
- **b.** to undertake some acts over a period of time,
- **c.** to otherwise engage in activities, or
- **d.** 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.

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

"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 Identifier" and **"NPI"** each means the unique 10-digit identification number issued to a health care Provider in the United States by CMS.

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

"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 Sec. 21 of Ex. B, Part 8 of this Contract.

"No Credibility" means the experience of a CCO is determined, under CMS guidance[11], to be insufficient, measured in terms of member months, for the reliable calculation of a MLR. A CCO that is assigned No Credibility (or is Non-credible) will not be measured against any MLR requirements.

"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-Medicaid Contract" means the separate contract # «NonMedicaid_Contract_» that Contractor has entered into with OHA to provide non-Medicaid funded OHP Plus-equivalent benefits to certain individuals not eligible for Medicaid.

[11] https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf

"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.

"Non-Quantitative Treatment Limitation" and **"NQTL"** each means a limitation that is not expressed numerically but otherwise limits the scope or duration of Behavioral Health Coverage, such as medical necessity criteria or other Utilization Review.

"**Non-rural**" means, as used in Ex. C, Sec. 1, Para. d, Sub.Para. (2) only, both "urban area" and "large urban area" as defined in OAR 410-141-3515.

"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 OHA Encounter Data liaison as set forth in Ex. B, Part 8, Sec. 10.

"Notice of Potential At-Risk Overpayment" means a written notice sent to Contractor from the Office of Program Integrity regarding a potential Overpayment.

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

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

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

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

"Nutrition-Related Supports" 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 a 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 Department of Human Services" and **"ODHS"** each has the meaning provided for in OAR 410-120-0000.

"Oregon Health Plan Bridge-Basic Health Program Contract" and **"OHP Bridge-BHP Contract"** each means the Health Plan Services Contract, Coordinated Care Organization Contract # «BHP_Contract_» effective July 1, 2024, under which Contractor provides services substantially similar to those covered under the Medicaid and Non-Medicaid Contracts to individuals entitled to such services in accordance with OAR 410-200-0438 and in the same Service Area as both of the aforementioned contracts.

"Oregon Health Plan Plus" and **"OHP Plus"** each means the benefit package described in OAR 410-120-1210.

"Oregon Medical Loss Ratio" and **"Oregon MLR"** each means the proportion of premium, Quality Pool, and Challenge Pool revenues (net of taxes) spent on incurred claims, including activities that improve health care quality, Quality Pool, and Challenge Pool expenditures, as specified in the MMLR Template and Instructions. The Oregon MLR does not include revenue and expenditures related to separate payment term Qualified Directed Payments. As permitted by CMS, the Oregon MLR is defined separately from the Federal MLR for purposes of calculating the MMLR and any associated rebate.

"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, Sec. 18 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.

"Outpatient Problem Gambling Treatment Services" has the meaning provided for in OAR 309-019-0105.

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

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

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

"Pantry Stocking Benefit" means a service that allows a Member who has been authorized for the Pantry Stocking Benefit to obtain or otherwise receive supplemental groceries from a vendor that is enrolled with OHA as a Medicaid provider. The Pantry Stocking Benefit includes fresh, frozen, pureed, dried, or canned grocery items (or all or any combination thereof).[12]

"Partial Credibility" means the experience of a CCO is determined under CMS guidance to be sufficient, measured in terms of member months, for the calculation of a MLR but with a non-negligible chance that the

[12] OHA expects to propose administrative rules effective 1/1/2026 that may supersede this contract language.

difference between the actual and target medical loss ratios is statistically significant. A CCO that is assigned Partial Credibility (or is Partially Credible) will receive a credibility adjustment to its MLR.

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

"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.

"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).

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

"Peer" 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.

"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.

"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:

- **a.** quality or access to services are not being provided as required under the Contract,
- **b.** cost containment goals are being compromised,
- **c.** circumstances exist that affect Member rights or health, or
- **d.** 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 ODHS under OAR 461-195-0303.

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

"Pharmacy Benefit Manager" and **"PBM"** each has the meaning provided for in ORS 735.530.

"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.

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

"Post-Release Case Manager" means a Provider who (i) meets the reentry targeted case management Provider qualifications ~~and is responsible for providing~~described in OAR 410-138-0060[13] and (ii) provides the reentry targeted case management services, which are included in the Reentry FCAA Services, to FCAA-Covered Youth for at least thirty (30) days after such Youth is released to the community ~~as described in OAR 410-138-0060.[14]~~.

"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:

a. 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

b. that complies with OAR 410-141-3855.

"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.

"Pre-Release Case Manager" means a provider who (i) meets the reentry targeted case management provider qualifications ~~and is responsible for providing~~described in OAR 410-138-0060[15] and (ii) provides the reentry targeted case management services, which are included in the Reentry FCAA Services, to the FCAA-Covered Youth during their ~~pre-~~Pre-Release Period.

"Pre-Release Period" refers to the thirty (30) day time period prior to an FCAA-Covered Youth's expected release ~~period as described in OAR 410-138-0060.[16]~~ from a Correctional Facility.[17]

"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,

[13] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.
~~[14] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.~~
[15] This term will be defined in OAR 410-138-0060 effective 1/1/2026 and supersede this contract language.
~~[16] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.~~
[17] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

mitigation, or prevention of disease, or health maintenance that are:

a. 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;

b. Dispensed by licensed pharmacists and licensed, authorized practitioners in accordance with the applicable licensing agency; and

c. Dispensed pursuant to a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

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

"Prevalent Non-English Language" has the meaning provided for in OAR 410-141-3575.

"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).

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

"Prioritized List of Health Services" and **"Prioritized List"** each has the meaning provided for in OAR 410-120-0000. Current and past versions of the Prioritized List are available the following OHA website: https://www.oregon.gov/oha/hpa/dsi-herc/pages/prioritized-list.aspx.

"Program Integrity Audit" and "PI Audit" each means, but is not limited to, the review of Medicaid claims for suspicious aberrancies to establish evidence that fraud, waste, or abuse has occurred, is likely to occur, or whether actions of individuals or entities have the potential for resulting in an expenditure of Medicaid funds which is not intended under the provisions of this Contract, State or Federal Medicaid regulations, and whether improper payment has occurred.

"Proposed SMED Report" means that proposed Subject Month Encounter Data Report described in Ex. B, Part 8, Sec. 14 of the Contract.

"Protected Information" means all forms of personally identifiable client, Member, patient, or Provider 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:

a. 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;

b. Drug and alcohol records as defined and protected under 42 USC § 290dd-2, 42 CFR part 2, and ORS 430.399(6);

c. Genetic information as defined and protected under ORS 192.531 to 192.549;

d. Communicable disease information as defined and protected under ORS 433.008 and ORS 433.045(4);

e. Medical assistance records as defined and protected under 42 USC § 1396a(a)(7), 42 CFR § 431.300 to 431.307, and ORS 413.175;

f. Other personal information as defined and protected under ORS 646A.600 to 646A.628;

g. Educational records protected under FERPA and those protected under the Individuals with Disabilities Education Act;

h. Child welfare records, files, papers, and communications provided for under ORS 409.225;

i. Child abuse reports protected under ORS 419B.035;

j. Abuse records of adults with developmental disabilities or mental illness provided for under ORS 430.763;

k. Elder abuse records and reports and any compilation thereof in accordance with ORS 124.090;

l. Data provided to or created by or at the direction of a peer review body as defined and protected under ORS 41.675;

m. Privileged communications as set forth under ORS 40.225 through ORS 40.295; and

"Prospective Payment System" and **"PPS"** each means the payment methodology described in 42 USC 1396a(bb) that is applicable to Federally Qualified Health Centers and Rural Health Centers.

"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" means the same as **"Delivery System Network**", which has the meaning provided in OAR 410-141-3500.

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

"Provider Termination" means the termination of Provider's contract with Contractor, or a prohibition of Provider's participation in OHA Health Services Division programs 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.

"Public Safety Power Shutoff" and **"PSPS**" each has the meaning provided for in OAR 410-120-0000.

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

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

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

"Quality Assessment 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 CFR § 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 QAPI.

"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 Ex. C.

"Race, ethnicity, preferred spoken and written languages and disability status standards" and **"REALD"** each means the standards under ORS 413.161. As of July 1, 2022, pursuant to Enrolled Oregon House Bill 3159 (2021) Section 5, sexual orientation and gender identity are added to the standards under ORS 413.161.

"Readily Accessible" has the meaning provided for in OAR 410-141-3500.[18]

"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.

"Reentry Care Plan" and **"RCP"** each means a plan that is documented through case management activity undertaken by a case manager who is identified by, and with the participation of, the FCAA-Covered Youth. Such case manager is responsible for drafting a Reentry Care Plan that documents, with the Member's input, the goals and actions (e.g., referrals, appointment scheduling), that address the medical, mental, substance use, housing and other health-related social needs, functional needs, and strengths and support resources needed and identified by the Member.[19]

"Reentry FCAA Services" means the defined set of Medicaid and CHIP services that must be provided to FCAA-Covered Youth, as required under Section 5121 of the FCAA. Services include:[20]

a. Screening and diagnostic services in the thirty (30) days prior to release, or no later than one (1) week, or as soon as practicable, after release; and

b. Targeted Case Management in the thirty (30) days prior to release and for at least thirty (30) days post-release (as defined in OAR 410-138-0000).

"Reentry Health Risk Assessment" and **"Reentry HRA"** each means a comprehensive, assessment of an FCAA-Covered Youth that is gathered by a Post-Release Case Manager from such Youth's history and other sources, such as family members, medical providers, social workers, and educators (if necessary), that forms a complete, documented assessment of the FCAA-Covered Youth. The Reentry HRA must be completed within thirty (30) days after the FCAA-Covered Youth in released to the community and includes the Post-Release Case Manager identifying and documenting the FCAA-Covered Youth's needs including the extent and nature of the Member's needs as they return to the community as described in OAR 410-155-0010.[21]

"Reentry Warm Handoff" is a required transition meeting attended by the Pre-Release Case Manager, Post-Release Case Manager, and the Member when the Pre-and Post- Release Case Managers are different in order to ensure a supportive reentry process, continuity of case management, and scheduling or otherwise arranging

[18] This existing OAR will be updated effective 1/1/2026.
[19] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.
[20] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.
[21] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

for a follow-up meeting with the Post-Release Case Manager once the FCAA-Covered Youth transitions into the community.[22]

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

a. those report templates, reference documents, guidance documents, or other documentation referred to in the Contract,

b. required or otherwise recommended to be used or referenced in performing the obligations or meeting the conditions of the Contract, and

c. posted on or accessed through one or more webpages on OHA's website, including, without limitation, OHA's CCO Contract Forms Website.

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

"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 a Person that has a common interest with Contractor as a result of ownership, control, or affiliation. A Related Party to Contractor includes, but is not limited to, a Person or Persons **(i)** that provides to Contractor, either directly or indirectly through one or more unrelated parties: **(a)** administrative, management, or other essential services, **(b)** facilities, **(c)** supplies, or **(d)** financing; and **(ii)** is associated with Contractor by any form of affiliation, control, or investment. Based on the foregoing, a Related Party includes, without limitation, the following:

a. An Affiliate,

b. The principal owner(s) of Contractor,

c. Members of the immediate families of a Related Party or the principal owners of Contractor,

d. A party which can directly or indirectly significantly influence the management or operating policies of Contractor.

"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, 2028, 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.

[22] This term will be defined in OAR 410-155-0000 effective 1/1/2026 and supersede this contract language.

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

"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:

a. Enters into an arrangement or agreement with a coordinated care organization to provide health services to Members of the coordinated care organization;

b. Assumes the financial risk of providing health services to medical assistance recipients; and

c. 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, depending on the parameters of the specific Risk Corridor, OHA and Contractor share in higher or lower than (or both) 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 except as used in Ex. C, Sec. 1, Para. d, Sub.Para. (2). In the context of the aforementioned provision, "Rural" means both "rural area" and "county with extreme access considerations" as defined in OAR 410-141-3515.

"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.

"Section 1557 of the ACA" and **"Section 1557"** each means Section 1557 of the Patient Protection and Affordable Care Act (PPACA or ACA) which prohibits discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics) in covered health programs or activities (42 U.S.C. 18116) and for which the amended federal regulations are effective April 26, 2024. The amended final regulations can be found at the following URL: https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities.

"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 Ex. B, Part 2, Sec. 3 of this Contract.

"SHARE" means the SDOH-E spending program as described 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" has the meaning provided for in OAR 410-141-3500.

"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.

"Stabilization Services" has the meaning provided for in OAR 309-072-0110.

"State" means the State of Oregon.

"State 1115 Waiver" means the 1115 Waiver issued to Oregon by CMS on September 28, 2022, for the period beginning October 1, 2022, and ending September 30, 2027. 1115 waivers are issued by CMS in accordance with Section 1115 of the Social Security Act pursuant to which CMS waives federal guidelines relating to Medicaid in order to permit states, including Oregon to pilot and evaluate innovative approaches to serving Members.

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

"State Quality Strategy" means OHA's written quality strategy for assessing and improving the quality of health care and services furnished by CCOs required by 42 CFR § 438.340(a). Oregon's State Quality Strategy is located on OHA's CCO Quality Assurance webpage at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA.aspx.

"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. 12, 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 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.

"Substance Use Disorder Treatment and Services" means the treatment of and any services provided to address any Substance Use Disorder.

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

"SUD Community Integration Services" means housing transition and tenancy sustaining and employment supports to assist individuals transitioning back into the community from SUD treatment.

"SUD Day Treatment" means a Substance Use Disorders (SUD) program that provides assessment and clinically intensive treatment and rehabilitation 20 hours or more each week to support individuals who need daily monitoring and management in a structured outpatient setting consistent with ASAM Level 2.5.

"Supplemental Health Benefit State Funding" has the meaning provided for in OAR 410-120-0000. In some instances, Supplemental Health Benefit State Funding may be referred to as "SHB" in this Contract.

"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.

"Telehealth" has the meaning provided for in OAR410-120-1990.

"Term" means the entire nine-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 Sec. 1.1 of the General Provisions and as otherwise provided for in this Contract, on December 31, 2028.

This nine-year Term reflects the following: (i) the original five-year Term of the Contract~~;~~ (which was to expire on December 31, 2024); (ii) the two-year extension pursuant to Section 2, Chapter 441, Oregon Laws 2023~~;~~ (up to and including December 31, 2026); (iii) and the additional two-year extension up to and including December 31, 2028, pursuant to OHA's ~~exercise of its~~ authority ~~provided in~~under Section 2 of Enrolled Oregon House Bill 2205 (2025). 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:

a. The pregnancy is the result of an act of rape or incest; or

b. The individual 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 individual 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.

"Total Overpayment Alleged in a Final PI Audit Report" means the total Medicaid Overpayment amount from a Contractor's PI Audit or investigation which is final on the date that (i) if Contractor allows appeals of Contractor's finding(s) and the Provider requests an appeal, Contractor makes its final determination on the appeal, (ii) if Contractor allows appeals of Contractor's finding(s) and the Provider does not request an appeal, the time period for a Provider to appeal Contractor's finding(s) expires, or (iii) if Contractor does not allow appeals of Contractor's finding(s), Contractor's finding(s) are final.

"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 950-060-0010.

"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 Ex. D of the Contract.

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

"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 Ex. 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.

"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.

"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.

"Tribal Sovereignty in the United States" and **"Tribal Sovereignty"** each means the inherent authority of indigenous tribes to govern themselves within the borders of the United States of America. The U.S. federal government recognizes tribal nations as "domestic dependent nations" and has established a number of laws attempting to clarify the relationship between the federal, state, and tribal governments. *See Cherokee Nation v. Georgia*, 30 US (5 Pet.) 1, 17 (1831) and the U.S. Department of Justice Policy on Indian Sovereignty (June 1, 1995) found at the following URL: https://www.justice.gov/archives/ag/attorney-general-june-1-1995-memorandum-indian-sovereignty.

"Tribal Traditional Health Worker" has the meaning defined in ORS 414.025.

"Tribe(s)" and **"Tribe(s) in Oregon"** each 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:

- **a.** providing better care to Members,
- **b.** improving Member health, and
- **c.** 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, Sec. 2, Paras. 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:

- **a.** Can be processed without obtaining additional information from the Provider of the service; and
- **b.** Has been received within the time limitations prescribed in OAR 410-141-3565. 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) and OAR 410-141-3875.

"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:

a. Foundational Payments for Infrastructure and Operations,

b. Pay for Reporting,

c. Rewards for Performance/Penalties for Performance,

d. Shared savings,

e. Shared risk,

f. Partial Capitation or Episode-based Payments,

g. Comprehensive Population-based Payment, and

h. Integrated Finance and Delivery System.

"Very Low Food Security" has the meaning provided for in OAR 410-120-0000.

"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.

"Withdrawal Management" means monitoring and managing an individual's symptoms for the purpose of preventing or alleviating clinical complications related to no longer using, or decreasing the use of, a substance. Services are consistent with all ASAM levels for withdrawal management: 1.0-WM, 2.0-WM, 3.2-WM, 3.7-WM, and 4.0-WM.

"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" has the meaning provided for in OAR 309-019-0162.

"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" has the meaning provided for in OAR 309-019-0162.

"Young Adults with Special Health Care Needs" and **"YSHCN"** each has the meaning provided for in OAR 410-120-0000.

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

"Youth Support Specialist" has the meaning provided for in OAR 950-060-0010.

~~*[Remainder of page intentionally left blank]*~~

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

1. Governing Board and Governance Structure

a. Contractor shall establish 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.[23]

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 Sec. 1 and its Governing Board and its key committee descriptions as required under Para. c above of this Sec. 1 to OHA, via Administrative Notice, by no later than January 30 of each Contract Year.

e. Contractor shall comply with all applicable provisions of Enrolled Oregon Senate Bill 951 (2025) and Enrolled Oregon House Bill 3410 (2025), both of which relate to management services organizations.

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 (**"TAC"**) is responsible for, among other matters, serving as a channel of communication between

[23] This existing OAR will be updated effective 1/1/2026.

Contractor, other CCOs, and Tribes in Oregon regarding the health of Tribal communities. In order to facilitate communication between the Tribal communities and Contractor, the TAC 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 Ex. 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 TAC 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 Tribal communities and the coordinated care health care system.

c. Contractor shall ensure that the Tribal Liaison's primary title and job responsibilities are those described in Paras. a and b above as well as Para. c below of this Sec. 3 and that any other tasks, activities, and responsibilities that may be required to be performed by the Tribal Liaison do not conflict with, supersede, or otherwise interfere with their primary obligations. Contractor shall also ensure that:

(1) The Tribal Liaison is provided with a written copy of the job description and that any and all job postings for the position of Tribal Liaison comply with this Sec. 3; and

(2) The Tribal Liaison is invited to all meetings, including those of Contractor's decision-making body(ies), that may impact Contractor's relationships with one or more Tribes or with American Indian or Alaska Native Members (or all or any combination thereof). Contractor shall use best efforts to schedule such meetings at times and locations that do not conflict with the Tribal Liaison's other job responsibilities or commitments; and

(3) The Tribal Liaison reports directly to an individual within Contractor's leadership team and nothing shall preclude the Tribal Liaison from having direct access to, notwithstanding the position held by the individual to whom the Tribal Liaison reports, Contractor's executive leadership; and

(4) Contractor, including Contractor's executive leadership, receives training on the Indian Health Care Delivery System, including Tribal history, the Trust Responsibility, and Tribal Sovereignty.

d. Upon request, OHA will provide Contractor and its Tribal Liaison with technical assistance in meeting their respective responsibilities. OHA has developed a Guidance Document, which includes a sample Tribal Liaison job description, to further assist Contractor and the Tribal Liaison. The Guidance Document is located on the CCO Contract Forms Website and will be updated from time to time as may be necessary.

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, (iv) working with Contractor and its governing body, and (v) 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.

[Remainder of page intentionally left blank]

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 Health.

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 as provided in OAR 410-141-3830.

e. Except as otherwise provided in OAR 410-141-3820,[24] 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, 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. 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.

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

[24] This existing OAR will be updated effective 1/1/2026.

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 (UM) 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. Any such request and response shall be made by the parties 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 Sec. 2, Ex. B, Part 2 and any other applicable provisions of this Contract. OHA will notify Contractor within thirty (30) days from the due date, or within thirty (30) days from the received date if after the due date, 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 minimum standards specified by OHA, 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). OHA's minimum standards are provided in the document titled "Minimum Standards for DUR Programs" posted to the CCO Contract Forms Website. As specified in OHA's minimum standards, Contractor shall:

(a) Have prospective safety edits on initial and 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) Have prospective safety edits and claims review automated processes to identify when a patient is prescribed an opioid after a recent diagnosis of opioid use disorder or a prescription used to treat opioid use disorder;

(d) Have edits or processes to identify when a patient may be at high risk of opioid overdose and should be considered for co-prescription or co-dispensing of an FDA-approved opioid antagonist/reversal agent (naloxone);

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

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

(g) 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 develop and maintain written policies and procedures (P&Ps) that comply with Section 1927 of the Social Security Act and 42 CFR, Part 456, Subpart K. Without limiting the foregoing, Contractor 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. Contractor shall submit its DUR Program P&Ps to OHA upon request, within five (5) Business Days of the request and in the manner and to the location identified by OHA in the request.

(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.

h. Contractor shall participate in the palliative care program described in Enrolled Oregon House Bill 2981 (2021) and in accordance with the requirements specified in OAR 410-141-3846.

i. Contractor shall comply with the requirements related to gender-affirming treatment specified in Section 24 of Enrolled Oregon House Bill 2002 (2023) applicable to CCOs and as specified in the applicable OARs.

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[25] 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;

[25] This existing OAR will be updated effective 1/1/2026.

(4) Consistent with OAR 410-141-3835, 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, and Members may Refer themselves to Behavioral Health services available from the Provider Network;

(5) Contractor shall not require, as set forth in OAR 410-141-3835, Members to obtain Prior Authorization for Medication-Assisted Treatment (**"MAT"**) from within Contractor's Provider Network. However, Contractor may, but is not obligated to, require Members to obtain Prior Authorization for MAT as otherwise permitted under OAR 410-141-3835. Notwithstanding the requirement relating to Contractor's Provider Network in this Sub.Para. (5), 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. 3 of this Ex. B, Part 2 shall apply to each episode of care;

(6) Members shall have the right to obtain certain Behavioral Health services from within Contractor's Provider Network without Prior Authorization as specified in OAR 410-141-3835, except that Contractor shall require Prior Authorization for applied behavior analysis (ABA), electroconvulsive therapy (ECT), neuropsychological evaluations, and transcranial magnetic stimulation (TMS).

(7) Members shall have the right to refer themselves to:

(a) A Traditional Health Worker for services within the scope of practice defined in Oregon Administrative Rules;

(b) Covered family planning services from out-of-network Providers as described in Ex. B, Part 2, Sec. 6, Para. b;

(c) Health-Related Social Needs Services in accordance with OAR 410-120-2015; and

(d) Doulas, Lactation Counselors, and Lactation Educators, pursuant to ORS 414.668.

(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 pay Indian Health Care Providers as specified in Ex. B, Pt. 8, Sec. 5, Para. g. OHA will provide Contractor with the IHS and Prospective Payment System (PPS) encounter rates for IHCPs upon request. Further, OHA will provide a Guidance Document to assist Contractor with complying with IHCP payment requirements, including information about which services are excluded from the IHS and PPS encounter rates. Contractor shall comply with all other applicable payment obligations relating 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)(i)(B), Contractor shall provide notice to, in response to all standard Service Authorization Requests, the requesting Provider as expeditiously as the Member's physical health, Oral Health, or Behavioral Health condition requires, not to exceed seven (7) 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 seven (7) day timeframe, 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. (11) of this Para. b, Sec. 3, 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 Ex. I of this Contract. Upon request, Contractor shall also provide the information it provides to Members and Providers under this Sub.Para. (11), 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 Ex. 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) For authorization decisions involving repair to Complex Rehabilitation Technology, Contractor shall provide a response within seventy-two (72) hours following receipt of the request, in accordance with OAR 410-141-3835.[26]

(15) 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;

[26] This existing OAR will be updated effective 1/1/2026 for Enrolled Oregon Senate Bill 549 (2025) relating to Complex Rehabilitation Technology and for other changes.

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

(17) 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. (16), 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.

(18) 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

(19) 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 Ex. I of this Contract.

c. In compliance with 42 CFR § 438.210(f), Contractor shall submit to OHA, via Administrative Notice, Prior Authorization (PA) data, excluding data on any and all Prescription Drugs covered by Contractor, by March 31st of each Contract Year for the prior Contract Year. Contractor shall publicly post such PA data on its website. OHA will provide a Guidance Document and reporting template to assist Contractor in complying with this provision.

~~c.~~d. In accordance with 42 CFR § 438.102(a)(2), Contractor is not required, subject to compliance with this Para. ~~c~~d, 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 develop and maintain a policy documenting such information and submit it to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

(2) Contractor shall furnish its policy of non-coverage 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.

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 § 438.114, 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, including Behavioral Health, or requires Dental Emergency Services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical 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 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, consistent with 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 and under Para. e of this Sec. 5, Ex. B, Part 2.

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 (P&Ps) that comply with this Contract and Applicable Laws and that describe the process for receiving Member requests, approving NEMT Services, and scheduling, assigning, and dispatching Providers. Contractor shall submit its NEMT P&Ps within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

d. NEMT rider information must be provided to all Members either in Contractor's Member Handbook or in a stand-alone document, which shall be referred to as a "NEMT Rider Guide." Whether included in Contractor's Member Handbook or in a stand-alone NEMT Rider Guide, NEMT rider information must meet the delivery and content specifications set forth in OHA's "NEMT Rider Guide Submission and Review Guidelines" document posted on the CCO Contract Forms Website. As applied to NEMT rider information in Contractor's Member Handbook, OHA regards the aforementioned "NEMT Rider Guide Submission and Review Guidelines" as a component of the Member Handbook Evaluation Criteria referenced in OAR 410-141-3585(12).

(1) Contractor shall provide to OHA, via Administrative Notice, its NEMT Rider Guide for review and approval: (i) Annually, not earlier than September 1 and not later than October 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. The NEMT Rider Guide is a deliverable that is separate and distinct from the NEMT policies and procedures described in this Sec. 5 of Ex. B, Part 2; OHA will not accept the NEMT Rider Guide as Contractor's NEMT policies and procedures.

(2) 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.

(3) Contractor may provide the NEMT Rider Guide to Members via electronic communications without the Member's consent, consistent with the purposes set forth in 42 CFR § 438.10, subject to the following conditions:

(a) The recipient has not requested that their correspondence be in written, hard copy format;

(b) The identical information is available in written, hard copy format and is provided to Members within five (5) Business Days of their request;

(c) Language and alternative format accommodations are available;

(d) All HIPAA requirements are satisfied with respect to personal health information;

(e) The information is placed in a prominent location on Contractor's public website and is in Readily Accessible digital format; and

(f) The electronic communication includes an easy means to opt out of future electronic messages and specify another means of delivery at any time.

e. Contractor's NEMT P&Ps 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 may include, without limitation, all expressions of dissatisfaction related to (i) driver or vehicle safety, (ii) quality of services, (iii) interactions with NEMT Providers or NEMT drivers, such as rudeness, (iv) access to services, and (v) consumer rights. A Member may express dissatisfaction about a denial of a service, in full or in part, through Contractor's Appeal process.

(b) If Contractor Subcontracts its NEMT Service obligations to a Subcontractor, neither the Subcontractor nor Contractor shall preclude Members from making Grievances that have been made previously or from filing or submitting the same Grievance to Contractor if the Grievance was not resolved to the Member's satisfaction at the Subcontractor level.

(c) Contractor shall have a process for documenting, responding to, and addressing or otherwise resolving all Grievances, regardless of whether such 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 Flexible 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 the Covered Service or Flexible Service is 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 Dual Special Needs 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,[27] 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;

(d) Frequently cancels or does not show up for the scheduled NEMT Services on the date such Service is to be provided; or

(e) Exhibits chronic lateness.

(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;

[27] This existing OAR will be updated effective 1/1/2026 to define "chronic lateness" and add it as a service modification.

(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 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 Providers 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 as well as local licensing and permit requirements and are operated by drivers who meet all of the requirements of, and have undergone all of, the pre-hire activities required under OAR 410-141-3925, which include verification of State driver's license with any required endorsements, screening for exclusion from participation in federal programs, and background checks.

(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 ninety (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 Sec. 5 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 pick-up date, time, and address and the name and address of the Provider to whom the Member seeks transport. Contractor is not responsible for arranging Transportation when the Member uses public transportation or when the Member or another person receives a mileage reimbursement or similar for transporting the Member.

(a) Contractor shall ask the Member to provide the scheduled pick-up date, time, and address and the name and address of the Provider to whom the Member seeks transport when Transportation is scheduled.

(b) Contractor shall provide the name and telephone number of the NEMT driver or NEMT Provider to the Member and confirm the scheduled pick-up time and address with the Member not less than two (2) days prior to the scheduled pick-up time. If the ride is requested less than two (2) days prior to the scheduled pick-up time, Contractor or its Subcontracted NEMT brokerage shall provide the Member with the brokerage's phone number and may, but is not required, to provide the Member with the name and telephone number of the NEMT driver or NEMT Provider.

(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 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. 32, Ex. D.

(a) Within two (2) Business Days of Contractor becoming aware of the Incident to the destination indicated in Exhibit D-Attachment 1.

(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 Flexible 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 Flexible 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, at a minimum, have the same days and hours of operation as those specified in OAR 410-136-3020(13)(a) pertaining to FFS NEMT brokerages. Contractor may close the call center on the same holidays listed in OAR 410-136-3020(13)(a). The Authority may approve, in writing, additional days of closure if Contractor requests the closure at least thirty (30) days in advance. Contractor shall submit such requests to OHA via Administrative Notice. 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 percent (80%) of all calls are answered by a live voice within forty-five (45) 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 forty-five (45) 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 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. The welcome message for the NEMT Call Center shall be in both English and Spanish. Contractor may establish a dedicated queue for Providers to access the NEMT Call Center as well as alternative scheduling methods for Providers, such as online scheduling.

(8) Contractor shall develop an NEMT Call Center script for calls requesting NEMT Services. The script shall include a sequence of questions and criteria that the NEMT Call Center representatives must 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. The script shall be written at the sixth (6^{th}) grade reading level since its primary intended audience is Members. In this script, 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 to/from the NEMT Call Center 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 were provided 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; 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 on all drivers including criminal history, driving history, sex offender status, and drug testing;

iv. Ensuring drivers and the vehicles used to provide NEMT services have undergone and met all pre-hire standards, qualifications, and training requirements set forth in OAR 410-141-3925 prior to providing services;

v. Obtaining and addressing accurate and timely information, for each driver, about any violation of a state drug law and the driver's driving history, including any traffic violations;

vi. 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.

vii. Verifying, and documentation thereof, NEMT Service Subcontractors have and maintain appropriate workers' compensation, general liability, and automobile liability insurance; and

viii. 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 about its NEMT operations, including its NEMT Call Center, and submit such data to OHA on an annual basis using the NEMT Quality Assurance (QA) Guidance Document and reporting template provided on the CCO Contract Forms Website. Such annual data reporting shall not be Delegated by Contractor to a third-party. Contractor is responsible for validating and submitting the annual NEMT QA Report. All such data collection and documentation is subject to the requirements set forth in OAR 410-141-3520.

(a) Contractor's annual NEMT QA Report shall be provided to OHA, via Administrative Notice, by no later than forty-five (45) days after the end of each Contract Year.

(b) Contractor shall analyze data collected about its NEMT operations, including the NEMT Call Center, 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.

(c) OHA will periodically validate the accuracy and completeness of the data in Contractor's annual NEMT QA Report. If OHA determines the data (i) is submitted in an invalid or incorrect format, or (ii) contains invalid or incorrect values for required data elements, or (iii) both (i) and (ii), OHA shall have the right to require Contractor to correct the data. If data errors are persistent, as defined by OHA in its reasonable discretion, OHA shall have the right to pursue any and all of its rights and remedies under this Contract.

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) Preventive 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 preventive 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 preventive 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 preventive 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) Contractor shall submit copies of all signed informed consents for sterilization and hysterectomy services to OHA, via Administrative Notice, in accordance with OAR 410-141-3570. OHA and Contractor shall reconcile all such informed consents with the associated Encounter Data as specified in OAR 410-141-3570. OHA's point of contact for activities involving the informed consents and Encounter Data is Contractor's Encounter Data liaison.

(4) 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. 12, Para. b, Sub.Paras. (16)-(18) of Ex. B, Part 9 and Sec. 16 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 (PHEC)

(1) PHEC is a twenty (20) day benefit included within the Global Budget Payment. As directed in Enrolled Oregon Senate Bill 296 (2025), OHA will submit a request to CMS to increase the PHEC benefit to one hundred (100) days. OHA anticipates that, if approved, the one hundred (100) day PHEC benefit will be effective January 1, 2026. OHA will provide prompt Administrative Notice to Contractor of the decision from CMS, including the effective date if the request is approved. 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 ODHS APD office prior to the Member being admitted to PHEC, in accordance with OAR 410-141-3870. 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 and in accordance with OAR 411-070-0033.

(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 Dual Special Needs 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 Contract 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 ODHS, 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 (OPDP); Agreements with Pharmacy Benefit Managers; Drug Coverage Criteria.

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

(2) In the alternative, Contractor may Subcontract with an entity other than OPDP for PBM services provided that its Subcontract with the PBM includes, in addition to those requirements set forth in Sec. 12 of Ex. B, Part 4 of this Contract, all of the provisions in this Para. e, Sec. 7, Ex. B, Part 2. 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 payments made by manufacturers to the PBM or its Affiliates that are attributable to Contractor's pharmacy claims;

(d) Fully participate and cooperate in the annual audit of compliance with the terms and conditions of the PBM contract between Contractor and the PBM. Participation and cooperation by Contractor shall be subject to the direction of the auditor.

i. The annual compliance audit must be performed by a neutral, unaffiliated third-party and be completed and delivered to Contractor by July 1 of each Contract Year;

ii. The audit must include, without limitation, a determination as to whether pharmacies were paid in accordance with the terms and conditions of the PBM Subcontract and a determination that all rebates and other payments made by manufacturers to the PBM or its Affiliates were passed through as described in this Contract, including, without limitation those provisions found in Sec.16 of Ex. B, Part 8.

iii. Contractor shall submit to OHA, via Administrative Notice, an executive summary of the annual PBM Subcontract compliance audit findings and a synopsis of any actions Contractor took as a result of the audit findings. Contractor shall use the template provided by OHA on the CCO Contract Forms Website. Contractor shall submit the executive summary of the audit report to OHA, via Administrative Notice, within seven (7) Business Days of Contractor's receipt of the audit report.

(e) Fully cooperate with Contractor to participate in an annual 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. Contractor shall use the template provided by OHA on the CCO Contract Forms Website to submit the findings of the third-party market check. Contractor shall submit the findings to OHA, via Administrative Notice, within seven (7) Business Days of receipt of the third-party market check by Contractor.

(f) Renegotiate and amend the Subcontract with Contractor whenever a third-party market check determines the PBM's actual performance is one percent (1%) or

more behind the current market in terms of aggregated gross plan pharmacy cost savings. Accordingly, the Subcontract with Contractor's PBM must include provisions that define the specific market check findings that trigger a review of pricing terms and when market check findings trigger a required renegotiation of terms with the Subcontractor. The Subcontract must explicitly require negotiation of improved terms that result from market check triggered amendments be made effective no later than October 1 of the evaluation year. For purposes of this requirement, "aggregated gross plan pharmacy cost savings" is defined as eligible charges plus all administrative fees paid to the PBM, The Subcontract may exclude claims from critical access pharmacies (as defined by Contractor) from the third-party market check.

(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 PBM's 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) Contractor shall submit to OHA, via Administrative Notice, the following document(s) relating to its PBM Subcontract:

(a) *By March 31 of each Contract Year:*

i. In the event Contractor Subcontracts with OPDP to provide PBM services pursuant to Para. e, Sub.Para. (1) of this Sec. 7: the OHA Attestation certifying that Contractor Subcontracts with OPDP; or

ii. In the event Contractor does not Subcontract with OPDP: (A) the Subcontract in effect as of the date of submission; (B) the completed OHA checklist that specifies all PBM Subcontract requirements; and (C) the completed OHA Attestation certifying that Contractor meets all PBM Subcontract requirements.

(b) In addition, prior to the effective date of any new or amended Subcontract executed subsequent to the submission required under Sub-Sub.Para. (3) (a) above: the document(s) specified in Sub-Sub.Para. (3) (a) applicable to the new or amended PBM Subcontract.

Without limiting any other rights or remedies OHA may have under this Contract, OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanctions if it

determines that Contractor's Attestation is false. Both the PBM Subcontract requirements checklist and Attestation form are provided on the CCO Contract Forms Website.

(4) 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.

(5) 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.

(6) 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.

(7) Contractor shall ensure that its medication coverage criteria comply with the requirements of Ex. B, Part 2, Sec. 2, Paras. b and e of this Contract. OHA will provide a Guidance Document for these requirements on the CCO Contract Forms Website.

f. Contractor shall provide all Members with the option to utilize mail order pharmacy services. At a minimum, mail order pharmacy services must include non-specialty medications, other than controlled substances, for chronic conditions. Contractor may satisfy the requirement for mail order pharmacy services through one or more retail pharmacies in Contractor's existing Provider Network, a separate mail order pharmacy network, or a combination thereof in order to meet the needs of Members. Contractor does not have the right to require Members to utilize mail order pharmacy services.

(1) Contractor shall inform Members about the option to utilize mail order pharmacy services through its Member Handbook. Such information shall include instructions for how to opt-in to the services and all terms and conditions associated with Members' use of the services.

g. With respect to Hepatitis C DAA Drugs, Contractor shall ensure that:

(1) Any preferred drug list as described in OAR 410-141-3855(3) includes, at a minimum, 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 (PMPDP). Contractor may continue to include other additional preferred Hepatitis C DAA Drugs on its preferred drug list, so long as doing so does not conflict with any Statewide Supplemental Rebate Agreement entered into by OHA;

(2) Contractor follows or has followed, in approving or denying all Members who have sought or seek approval for Hepatitis C DAA Drugs, the same criteria and Prior Authorization protocol as specified in the OHA-approved coverage criteria for FFS Members. Notwithstanding the foregoing, 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, provided that doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA; and

(3) Contractor has no conflicting supplemental rebates for Hepatitis C DAA Drugs. Contractor may continue to collect supplemental rebates for Hepatitis C DAA Drugs, provided that doing so does not conflict with any Statewide Supplemental Rebate Agreements entered into by OHA.

8. Covered Service Components: Other Services

a. Care Coordination

(1) Contractor shall provide Care Coordination to all members consistent with OARs 410-141-3860, 410-141-3865, and 410-141-3870 and 42 CFR § 438.208.

(2) Contractor shall develop and maintain Care Coordination policies and procedures ("CC P&Ps") that comply with OARs 410-141-3860, 410-141-3865, and 410-141-3870. Contractor shall submit its CC P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

(3) Contractor shall submit to OHA, via Administrative Notice, a bi-annual report on its Care Coordination activities no later than forty-five (45) days following the end of each six-month period. The report shall demonstrate Contractor's ability to fulfill the Care Coordination activities and requirements outlined in OARs 410-141-3860, 410-141-3865, and 410-141-3870. Contractor shall use the reporting template provided by OHA on the CCO Contract Forms Website.

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.

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.

(2) Contractor shall establish written policies and procedures for routine oral care, Urgent oral care, and Dental Emergency Services for children, pregnant individuals, and non-pregnant individuals that are consistent with OAR 410-141-3515. The policies and procedures must describe when treatment of an emergency Oral Health condition or urgent Oral Health condition should be provided in an ambulatory dental office setting, and when Dental Emergency Services should be provided in a Hospital setting.

(a) Routine Oral Health treatment or treatment of incipient decay does not constitute emergency care.

(b) The treatment of an emergency Oral Health condition is limited to Covered Services. OHA recognizes that some Non-Covered Services may meet the criteria for treatment of an emergency Oral Health condition; however, this Contract does not extend to those Non-Covered Services.

(3) Contractor shall make all reasonable efforts for its qualified representatives to meaningfully participate in OHA meetings and workgroups relating to the advancement and improvement of Oral Health in the state. Further, Contractor shall make all reasonable efforts to meaningfully engage third-party Oral Health stakeholders in meetings and activities that advance and improve Oral Health for Contractor's Members. Third-party Oral Health stakeholders may include dental providers, Dental Subcontractors, and other similarly interested third-parties.

e. Telehealth Services

Contractor shall ensure that Telehealth services meet all applicable requirements of OAR 410-120-1990, including requirements relating to Telehealth reimbursement, service delivery, patient choice and consent, access to care, and compliance with federal and state privacy and confidentiality rules.

9. Non-Covered Health Services with Care Coordination

Contractor must provide information in its Member Handbook about the availability of support from Contractor to access and coordinate care for Non-Covered Health Services with Care Coordination described in this Sec. 9 and how to request such support from Contractor. Additionally, Contractor is responsible for ensuring its Members have access to NEMT services for the services described in this Sec. 9.

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), also known as Planned Community Birth (PCB), services including prenatal and postpartum care for individuals 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 provisionally approved status. Further, OHA will be responsible for providing and paying for newborn initial assessment and newborn bloodspot screening test, including the screening kit obtained through Oregon State Public Health Laboratory. 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 in accordance with OAR 410-141-3826 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;

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

(3) Family Connects Oregon services;

(4) Prescription Drugs specified in OAR 410-141-3855[28] other than mental health drugs as described in Ex. B, Part 2, Sec. 9, Para. b, Sub.Para. (1) below. In the event OHA must obtain federal approval to carve out from this Contract any Prescription Drugs specified in OAR 410-141-3855, OHA will provide prompt Administrative Notice to Contractor if any such required federal approval is not granted. OHA will provide guidance to assist Contractor with complying with this contract provision. Such guidance will be included in the Guidance Document identified in Sub-Sub.Para. (a) of Sub.Para. (5) below relating to the CMS Access Model for cell and gene therapy to treat sickle cell disease;

(5) Cell and gene therapy (CGT) to treat sickle cell disease using the therapies identified in the CMS CGT Access Model contracts that CMS negotiated with bluebird bio, Inc. and Vertex Pharmaceuticals Incorporated, the two companies that manufacture the Access Model therapies ("Access Model"). (OHA entered into an agreement with CMS to participate in the Access Model, the details of which are available on the following CMS website: https://www.cms.gov/priorities/innovation/innovation-models/cgt.) Specifically, when the requested CGT therapy to treat sickle cell disease is identified in the Access Model, OHA will be responsible for determining medical necessity, issuing Prior Authorizations (PAs), and paying Providers for the therapy in accordance with OHA's PA. Contractor shall be responsible for all other Covered Services for Members approved by OHA to receive Access Model therapies to treat sickle cell disease in accordance with the applicable terms and conditions of this Contract. Such responsibilities shall include, but will not be limited to, inpatient and outpatient services, transportation, and Care Coordination. Contractor shall provide to OHA, upon request, documentation including, but not limited to, chart notes and other records that OHA determines are necessary for OHA to meet its reporting obligations to CMS.

(a) OHA will provide a Guidance Document to assist Contractor with understanding the Access Model and navigating the associated processes, including submission of and communication about PA requests.

(b) OHA will provide prompt Administrative Notice to Contractor of any changes to the therapies to treat sickle cell disease identified in the Access Model.

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:

[28] This existing OAR will be updated effective 1/1/2026 for the carve-out of (i) cell and gene therapies for sickle cell disease and (ii) high-cost drugs.

(1) Mental health drugs specified in OAR 410-141-3855 that include but are not limited to 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 group home reimbursed for Members under 21 years of age;

(3) Behavior Rehabilitation Services that are paid with Medicaid funds, regulated by OHA Medicaid, and administered by ODHS Child Welfare, the Oregon Youth Authority, and OHA Medicaid;

(4) Investigation of Members for Civil Commitment;

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

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

(7) 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;

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

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

(10) Abuse investigations and protective services as described in OAR Chapter 943, Division 45 and ORS 430.735 through 430.765;

(11) Personal care services as described in OARs 411-034-0000 through 411-034-0090, 410-172-0076 through 410-172-0800, and 410-173-0105 through 410-173-0110; and

(12) Enhanced Care Services and Enhanced Care Outreach Services as described in OAR 309-019-0155.

10. Non-Covered Health Services without Care Coordination

Contractor must provide information in its Member Handbook about the availability of support from OHA or its designee to access Non-Covered Health Services without Care Coordination described in this Sec. 10. Additionally, Contractor is responsible for ensuring its Members have access to NEMT services for the services described in this Sec. 10.

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;

e. Abortions; and

f. Traditional Health Care Practices as described in OAR 410-146-0470.

11. In Lieu of Services (ILOS)

Pursuant to 42 CFR § 438.3(e)(2), Contractor may offer In Lieu of Services to Members. The OHA In Lieu of Services Guidance Document and other ILOS-related information is available on the CCO Contract Forms Website and is updated from time to time as may be necessary.

a. The settings or services listed below are determined by OHA to be a Medically Appropriate and Cost-Effective substitute for a Covered Service consistent with provisions in OAR 410-141-3820. Contractor may choose to offer one or more of the following ILOS:

(1) Peer and Qualified Mental Health Associate Services - Alternative Setting

State Plan Service(s) In Lieu of: Psychosocial rehabilitation services.

Procedure codes: H0038, H2014, H2016, T1016.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes), GQ.

Target Population: Members with Behavioral Health conditions and/or health-related social needs (such as houselessness) that exacerbate or prevent effective treatment of Behavioral Health conditions.

Service Description: Outreach and engagement services provided by a certified Peer Support Specialist, Peer Wellness Specialist, Certified Recovery Mentor, or Qualified Mental Health Associate, to engage a Member in their care and provide ongoing support for enhancing wellness management, coping skills, independent living skills, and assistance with recovery. Services may be offered either prior to or after assessment and diagnosis, in clinical or community settings, in individual or group sessions, and may include drop-in services, care transition services, culturally specific services, and services focused on specific Member populations.

(2) Community Health Worker Services - Alternative Setting

State Plan Service(s) In Lieu of: Office or other outpatient visit, preventive medicine counseling or risk factor reduction (or both), skills training and development, comprehensive community support services.

Procedure codes: 98960-98962, 99211, 99401-99404, H2014, H0023, H2016.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members with (i) chronic conditions, (ii) Behavioral Health conditions, or (iii) health-related social needs (such as houselessness), or (iv) all or any combination of the foregoing, that exacerbate or prevent effective treatments.

Service Description: Evaluation and management of a Member by a certified Community Health Worker in community settings, such as housing or social service agencies that provide Culturally and Linguistically Appropriate Services. Services include providing preventive medicine counseling or risk factor reduction (or both), skills training and development, and comprehensive community support services. Services provided will: (i) support the Member to navigate the healthcare system, (ii) facilitate Member attendance at medical and other appointments, (iii) contribute to the Member's care team and planning, (iv) explain health and healthcare information, and (v) help the Member understand their own needs and locate services.

(3) Online Diabetes Self-Management Programs

State Plan Service(s) In Lieu of: Diabetes outpatient self-management training services.

Procedure codes: G0108, G0109, S9140, S9141, S9455, S9460, S9465, S9470, 97802, 97803, 97804, 99078.

Modifier(s): 93 and 95 for ~~telehealth~~Telehealth, V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members with diagnosis of type 1 or type 2 diabetes.

Service Description: Online training, support, and guidance provided by a health coach in synchronous or asynchronous individual or group sessions aimed at assisting a Member in controlling their daily blood glucose levels, managing their diabetes, and engaging in preventive health habits.

(4) National Diabetes Prevention Program - Alternative Setting

State Plan Service(s) In Lieu of: National Diabetes Prevention Program Services.

Procedure codes: 0403T, 0488T.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes), GT, 95.

Target Population: Members 18 years of age or older who have a body mass index of 25 or higher (23 or higher if Asian American), not previously diagnosed with type 1 or type 2 diabetes, and not pregnant.

Service Description: Provision of the National Diabetes Prevention Program (National DPP) by a Centers for Disease Control and Prevention (CDC) recognized program delivery organization.

(5) Chronic Disease Self-Management Education Programs - Alternative Setting

State Plan Service(s) In Lieu of: Patient self-management and education.

Procedure codes: 98961, 98962, S9445, S9446, S9451.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members at risk of developing type 2 diabetes; Members with type 1 or type 2 diabetes; Members under age 65 with an identified fall risk; Members age 65 and older (for fall prevention programs); Members with arthritis.

Service Description: Self-management programming to help a Member gain the knowledge and skills needed to modify their behavior and successfully self-manage their disease and its related conditions. Programs supported by OHA for this ILOS include the following covered programs offered in community settings: diabetes prevention programs (non-CDC recognized, or CDC-recognized), Diabetes Self-Management Program, *Programa de Manejo Personal de la diabetes*, Diabetes Self-Management Education and Support (DSMES), Walk with Ease Program, Stepping On: Falls Prevention Program, *Tai Ji Quan:* Moving for Better Balance, Matter of Balance, Otago Exercise Program, and other cultural, linguistic, or physically accessible adaptations of these programs.

(6) Infant Mental Health Pre- & Post-Testing Services

State Plan Service(s) In Lieu of: Psychological testing.

Procedure codes: 98960-98962, T1023.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes), HA.

Target Population: Members age 0-5 years old who are experiencing developmental delays, or having difficulty bonding with caregivers, or who may benefit from specialized programs.

Service Description: Tests, inventories, questionnaires, structured interviews, structured observations, and systematic assessments that are administered to help assess the Member and caregiver's relationship and to help aid in the development of the treatment plan.

(7) Lactation Consultations – Alternative Setting

State Plan Service(s) In Lieu of: Lactation consultations in office or other outpatient settings.

Procedure codes: 99202, 99212, 99401-99404.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

Target Population: Postpartum Members and their infants at higher risk of failure to breast/chest feed; Members who had a Cesarean delivery; Members who used substances during pregnancy; Members who are first time parents; Members recommended for lactation consultations by birth attendant or care team, pediatrician, Women, Infants and Children staff, Family Connects home visitor, or other maternity case management program.

Service Description: Preventive medicine and risk reduction counseling provided in a community setting by a registered nurse or a certified Traditional Health Worker with training in lactation (such as a certified lactation education counselor or certified breastfeeding specialist training).

(8) STI, Including HIV, Testing and Treatment Services – Alternative Setting

State Plan Service(s) In Lieu of: Office or other outpatient visit.

Procedure Codes: 36415, 96156-96171, 99202-99205, 99211-99215, 99401-99404, G0445.

Modifier(s): 93 and 95 for ~~telehealth~~Telehealth, V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members seeking testing and/or treatment for sexually transmitted infections (STI), including HIV, syphilis, gonorrhea, chlamydia, and other infections.

Service Description: Office or other outpatient visit for evaluation and management of a Member who may be a new or established patient. Preventive medicine counseling or risk factor reduction interventions provided to a Member. High intensity behavioral counseling to prevent sexually transmitted infection, which may: (i) be provided individually and face-to-face and (ii) include education, skills training, and guidance on how to change sexual behavior. The testing and treatment may involve venipuncture. Services to be provided by a registered nurse, physician's assistant, nurse practitioner, or physician in community settings, such as Local Public Health Authority clinics, community-based agency clinics, or testing events, or any combination thereof.

(9) Traditional Health Worker Services for HIV/STI Disease Management – Alternative Setting

State Plan Service(s) In Lieu of: Office or other outpatient visit, preventive medicine counseling and/or risk factor reduction, skills training and development, comprehensive community support services.

Procedure Codes: 98960-98962, H2014, H2016.

Modifier(s): 93 and 95 for ~~telehealth~~Telehealth, V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members at risk for or diagnosed with HIV or other STI.

Service Description: Evaluation and management of a Member will take place in community settings, such as community HIV/STI clinics, community-based organizations, syringe service programs, mobile clinics, and community-based outreach and testing events. Services include providing preventive medicine and high-intensity behavioral counseling or risk factor reduction (or both), skills training and development, and comprehensive community support services. Services provided will: (i) support the Member in navigating the healthcare system, (ii) facilitate Member attendance at medical and other appointments, (iii) contribute to the Member's care team/planning, (iv) explain health and healthcare information in a manner that the Member understands, and (v) help the Member understand their own needs and locate services.

(10) Chronic Care Management – Alternative Provider, Alternative Setting

State Plan Service(s) In Lieu of: Chronic care management by traditional providers.

Procedure Codes: 99439, 99487, 99489, 99490, 99426-99427.

Modifier(s): 93 and 95 for ~~telehealth~~Telehealth, V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members with higher risk of hospitalization or other adverse health events due to social risk factors; Members with barriers to transportation or other health-related social needs that limit or prevent (or both) access to chronic care management and effective treatments.

Service Description: Chronic care management services by alternative provider; may occur in community settings or residence of the Member. Services may include structured recording of patient health information, comprehensive care planning, managing care transitions and other care management services, or coordination and sharing the Member's health information with the Member's clinical care team. The service may be initiated after a provider referral.

(11) Home Changes for Health – Alternative Population

State Plan Service(s) In Lieu of: Acute outpatient or inpatient care for exacerbation of certain conditions due to extreme weather, or treatment of adverse health events that may be experienced due to extreme weather or poor air quality.

Procedure Codes: S5165, T2028, T2029.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

Target Population:

(i) Portable power supply: Members who use a medical device requiring electricity for use, and who do not already have a device sufficient to meet their needs.

(ii) Mini refrigerator: Members who use medication requiring temperature control, and who do not already have a device sufficient to meet their needs.

(iii) Air conditioner, portable heater and/or air filtration device: Members who have a health condition that is worsened by heat, cold or air quality, respectively, OR who have a higher risk of extreme weather-related adverse health events due to health-related social need(s), AND who do not already have a device sufficient to meet their needs.

Service Description: Home changes for health devices for alternative population can include devices such as air conditioners, portable heaters, air filtration devices, mini refrigeration units and/or portable power supplies (PPS), as well as installation of the device(s).

(12) Indicated Preventive Behavioral Health Services

State Plan Service(s) In Lieu of: Higher acuity behavioral health services, emergency department use or hospitalization.

Procedure Codes: 90832-90837, 90846-90847, 90849, 90853, 97153-97154, 97156-97157, H0038, H0046, H2014, H2019-H2020, H2 027, H2037, H2038, T1016.

Modifier(s): V4 (ILOS-specific modifier for tracking purposes).

Target Population: Members at risk of developing a behavioral health condition, or with signs/indicators of a developing behavioral health condition, and their family/caregiver(s). Signs, indicators, or risks of developing a behavioral health condition could include but are not limited to certain qualifying life events, captured with codes such as R45.7 (state of emotional shock and stress, unspecified) or Z62.820 (parent-child conflict).

Service Description: Indicated preventive behavioral health services may occur in community settings and may include: (i) anticipatory guidance and services, including skills training, (ii) group or individual education or psychoeducation, (iii) peer services, or (iv) individual, family, or group psychotherapy (or any combination thereof), including but not limited to coping strategies and skills development, including but not limited to social-emotional skills, emotional regulation strategies, distress tolerance, and parenting skills.

(13) Mobile Integrated Health Services – Community Services

State Plan Service(s) In Lieu of: Office or other outpatient visit, emergency department utilization or hospitalization.

Procedure Codes: 36415, 90460, 90471-90474, 90832-90847, 97535, 99211, 99341-99350, 99401-99404, 99424-99426, 99484, 99495-99496, 99600, H0038, H0046, H2014, H2019-H2020, H2038, Q3014, S9127, T1016.

Modifier(s): 93 and 95 for ~~telehealth~~Telehealth, V4 (ILOS-specific modifier for tracking purposes), CG, HE.

Target Population: Members with health-related social needs that limit and/or prevent access to care and effective treatments, including but not limited to (i) Members experiencing houselessness, (ii) Members with barriers to transportation, (iii) Members living alone or with social isolation, or (iv) Members who are seasonal/migrant laborers; Members diagnosed with chronic physical or behavioral conditions; Members with

previous trauma from a clinical setting; Members in need of preventive services such as not but not limited to vaccine administration.

Service Description: Mobile integrated health provided to a Member in a community setting or residence of the Member. Services may include: preventive supports, chronic condition support and treatment, care coordination, wraparound support, vaccine administration, post-discharge supports and services, transitional care management, peer services, mental and behavioral health services or telehealth appointment set-up assistance.

b. Contractor is not required to offer ILOS to Members. Notwithstanding the foregoing, Contractor shall consider using ILOS and Flexible Services when such use could improve a Member's health or resource efficiency (or both).

c. Contractor does not have the right to require Members to use ILOS in place of a Covered Service.

d. If Contractor offers ILOS, Contractor must ensure the ILOS are available to all Members who qualify.

e. Contractor shall only implement ILOS specified above in para. a of this Sec. 11. OHA will inform Contractor about the process for proposing new ILOS in the ILOS Guidance Document.

f. Contractor shall indicate in its Member Handbook whether it offers ILOS and, if it does, Contractor will identify which ILOS it does offer and provide Members with information about their rights related to ILOS.

g. In the event Contractor offers ILOS, Contractor shall identify ILOS Providers in the Provider directory as described in Ex. B, Part 3, Sec. 6. Additionally, OHA may require Contractor to identify ILOS Providers in its bi-annual Delivery System Network (DSN) Provider Capacity Report described in Ex. G, Sec. 2. OHA will notify Contractor, via Administrative Notice, about the effective date for inclusion of ILOS Providers in the bi-annual DSN Provider Capacity Report.

h. OHA may add ILOS to or remove ILOS from the list of approved ILOS identified above in Para. a of this Sec. 11 each Contract Year. Contractor may choose to offer or discontinue any approved ILOS at any time during the Contract Year.

(1) Prior to discontinuing an ILOS, Contractor shall ensure that no Member who has been authorized to receive such ILOS has their ILOS disrupted by the change. Disruption in the delivery of ILOS may be avoided by either permitting affected Members to complete the authorized service or by seamlessly transitioning the affected Members to other Medically Appropriate services or programs that adequately meet the Members' needs.

(2) Contractor shall notify affected Members in writing at least thirty (30) days in advance if the ILOS they are receiving will be discontinued.

i. Contractor shall ensure its contracted ILOS Providers have sufficient capacity to receive referrals for all Members who have been authorized to receive the approved, agreed-upon ILOS.

j. Contractor shall follow the process for Grievances and Appeals outlined in Ex. I for any Member whose request for authorization of an ILOS is denied, in full or part.

k. Contractor shall have written policies and procedures for ILOS Provider referrals. Contractor shall provide OHA, via Administrative Notice, with such policies and procedures within five (5) Business Days of request by OHA.

l. Contractor shall reimburse contracted ILOS Providers for the provision of authorized ILOS to Members. To the greatest extent possible, Contractor shall ensure ILOS Providers submit a claim for ILOS. In the event an ILOS Provider is unable to submit a claim, Contractor shall document the ILOS in the manner specified in the Guidance Document provided by OHA and posted on the OHA CCO Contract Forms Website.

m. OHA will include utilization of, and costs associated with, an ILOS in its development of CCO Payment Rates.

n. Contractor shall cooperate with OHA's efforts to comply with the contracting, reporting, and rate-setting requirements for ILOS as specified in 42 CFR § 438.3(e)(2). Contractor shall report the effectiveness of the use of ILOS in improving health and deterring higher cost care. Such reporting will be accomplished through an OHA developed monitoring and oversight process.

o. Contractor shall utilize a consistent process to ensure that a provider (either Contractor's licensed clinical staff or a Network Provider), using their professional judgment, determines and documents that the ILOS is Medically Appropriate for the specific Member, based on the clinically oriented target population.

p. Contractor shall refer to Ex. M, Sec. 2, Para h for the ILOS relating to inpatient mental health services provided at an Institution for Mental Diseases.

12. Family Connects Oregon

a. As specified in Ex. B, Pt. 2, Sec. 9, Contractor shall provide Care Coordination for Members receiving Family Connects Oregon (FCO) services. Contractor's Members who are newborns up to the age of six (6) months and whose OHP benefit package under this Contract includes physical health services are eligible for, in accordance with OAR 410-141-3826, FCO. OHA will produce a Guidance Document to assist Contractor with such Care Coordination and with supporting Member access to FCO services.

b. Contractor shall ensure that its Care Coordination activities for the newborn Member include communication and coordination with the FCO Provider if the family elects to participate in FCO.

c. OHA will pay Providers for FCO services on a Fee-for-Service basis.

d. OHA will attempt to utilize its internal Medicaid data systems as the source for the utilization data necessary for the FCO program annual reporting required under OAR 333-006-0160. If OHA's internal data systems do not contain all the required information, Contractor shall submit Reports to OHA, via Administrative Notice, using the template provided by OHA on the CCO Contract Forms Website and within the timeframe specified by OHA.

e. In order to support statewide and local implementation of FCO, Contractor shall coordinate with and provide Reports to OHA as follows:

(1) *Perinatal care coordination:* By January 15 of each Contract Year, Contractor shall provide Administrative Notice to OHA with the name and contact information of Contractor's designee for OHA activities related to perinatal care coordination and the FCO program. Contractor shall provide Administrative Notice to OHA within ten (10) days of any change in either its FCO program designee's name, contact information, or both.

(2) *FCO community alignment Report:* Contractor shall, in the manner prescribed by OHA in the associated Guidance Document, submit a bi-annual Report to OHA within forty-five

(45) days after the end of each six-month period on Contractor's engagement in FCO community alignment and planning activities. OHA will provide Contractor with a Guidance Document having details about the information to be reported.

13. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

a. Consistent with 42 CFR Part 441, Subpart B, Contractor shall meet the following requirements relating to Early and Periodic Screening, Diagnostic, and Treatment services for Members under age 21 and Members identified as YSHCN (**"YSHCN Members"**):

(1) *Informing requirements:*

(a) Contractor shall include, at a minimum, the information about EPSDT services listed below in its Member Handbook and on its website.

i. The benefits of preventive health care;

ii. The services available under the EPSDT program and where and how to obtain those services;

iii. That the services provided under the EPSDT program are without cost to the Member;

iv. That Non-Emergent Medical Transportation (NEMT) services are available for EPSDT services upon request; and

v. That assistance with scheduling appointments for EPSDT services is available upon request.

(b) Contractor shall inform Members or their Representatives who have not utilized EPSDT services of the availability of such services on an annual basis, following initial notification by provision of the Member Handbook.

(2) *Screening requirements:* Contractor shall provide and pay for EPSDT screening services identified in OAR Chapter 410, Division 151,[29] consistent with Ex. B, Part 2, Sec. 6 and in accordance with (i) the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care periodicity schedule for services provided in a primary care setting, which is located at the following URL: https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/, and (ii) the OHP Dental Periodicity Schedule for services provided in dental care setting, which is located at the following URL: https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx. Both of the foregoing screening services are identified in the preventive services guideline note in the Prioritized List.

(a) *Diagnosis and treatment requirements:* Contractor shall provide and pay for Covered Services indicated by EPSDT screenings consistent with Ex. B, Part 2, Sec. 6.

(3) *Timeliness requirement:* Contractor shall ensure timely initiation of treatment for Members with health care needs identified through EPSDT screenings.

(4) Contractor shall provide and pay for Members' NEMT services consistent with Ex. B, Part 2, Sec. 5 and OAR 410-141-3920.

[29] One or more rules in OAR Chapter 410, Division 151 will be updated effective 1/1/2026. Also, OHA expects to renumber the EPSDT rules in OAR Chapter 410, Division 151 during 2026.

(5) Contractor shall provide assistance, upon request, to Members or their Representatives in scheduling appointments and arranging for NEMT services consistent with 42 CFR § 441.62.

(a) If Contractor requires the Member's Primary Care Provider to provide assistance with scheduling appointments and arranging for NEMT services, Contractor shall specify such requirement in its written agreement with the Provider.

(6) Contractor shall provide referral assistance to Members or their Representatives for Covered Services and Non-Covered Services needed as a result of conditions disclosed during screening and diagnosis. Contractor shall also provide referral assistance to Members or their Representatives for, including but not limited to, social services, education programs, and nutrition assistance programs.

(7) Contractor shall not deny a Prior Authorization (PA) request or claim for payment of a healthcare service for a Member under age 21 or YSHCN Member without first reviewing it for EPSDT Medical Necessity and EPSDT Medical Appropriateness. If Contractor determines that the service is both EPSDT Medically Necessary and EPSDT Medically Appropriate, the PA request or claim must be approved regardless of whether: (i) it is below the funding line on the Prioritized List; or (ii) the associated diagnosis and procedure codes are not a Condition/Treatment Pair on the Prioritized List; or (iii) the service does not appear on the Prioritized List; or (iv) any combination thereof. Contractor's process for reviewing such PA requests and claims must comply with federal EPSDT requirements.

(8) OHA has developed a Guidance Document to assist Contractor with understanding the EPSDT requirements set forth in this Sec. 13. The Guidance Document includes information about the circumstances under which Contractor may deny a PA request or claim for a Member under age 21 or YSHCN Member, as permitted by Applicable Law. The Guidance Document is located on the EPSDT webpage at https://www.oregon.gov/oha/HSD/OHP/Pages/EPSDT.aspx and will be updated from time to time as may be necessary.

b. In addition to requirements specified in Para. a above and consistent with Section 7 of Enrolled Oregon Senate Bill 1557 (2024), Contractor shall ensure that Members under age twenty-one (21) have timely access to:

(1) EPSDT Medically Necessary and EPSDT Medically Appropriate services necessary to:

(a) Ensure the continuity of care for Members who are in out-of-home placements and move from one CCO to another CCO or are enrolled for the first time in a CCO; and

(b) Ensure that Members described in Sub-Sub.Para. (a) above of this Para. b have uninterrupted access to prescription medication, medical equipment, and supplies.

(2) Counseling, therapy, or mental health, or Substance Use Disorder treatment (or any combination thereof) with a Provider with whom the Member has an established relationship.

14. Healthier Oregon Program

The Healthier Oregon Program (HOP) benefit package provides OHP Plus-equivalent benefits to eligible individuals, which are delivered and paid for under this Contract and Contractor's separate Non-Medicaid Contract. The portion of the HOP benefit package paid under this Medicaid Contract is paid

with Emergency Health Benefit Funding and is referred to as "EHB." EHB is comprised of benefits that OHA may pay for utilizing federal funds received under Titles XIX and XXI of the Social Security Act. The portion of the HOP benefit package paid under Contractor's separate Non-Medicaid Contract is referred to as "SHB" (Supplemental Health Benefit State Funding). OHA utilizes only State of Oregon funds to pay for SHB.

a. EHB paid under this Contract expressly do not include:

(1) ILOS described in Sec. 11 of this Ex. B, Part 2 or organ transplants described in OAR Chapter 410, Division 124. ILOS and organ transplants for HOP Members are among the SHB paid under Contractor's Non-Medicaid Contract.

b. Contractor may, but is not required, to pay an amount similar to the Qualified Directed Payments within CCO Payment Rates described in Sub.Para. (2) of Ex. C, Sec. 1, Para. d for EHB-eligible services provided to HOP Members who are covered by this Contract.

15. Health-Related Social Needs Services: Member Identification, Screenings, Authorizations, Denials, and Notifications

Consistent with the State 1115 Waiver, Contractor shall meet the requirements set forth in this Sec. 15 relating to HRSN Services. Contractor shall provide and pay for Covered Services as required in this Ex. B, Part 2 and as additionally provided in this Contract. In accordance with OAR 410-141-3826, Contractor is responsible for all HRSN Services for eligible members who are enrolled with Contractor under plan type CCOA or CCOB.

a. HRSN Guidance Document. OHA will provide Contractor with an HRSN Guidance Document. The HRSN Guidance Document is located on the CCO Contract Forms Website and will be updated from time to time as may be necessary. Updates to the HRSN Guidance Document shall be considered effective thirty (30) days after OHA provides Administrative Notice thereof to Contractor. The HRSN Guidance Document addresses, at minimum, additional information and details for the following:

(1) HRSN Services,

(2) HRSN Service delivery: member identification, screening, and authorizations, and HRSN Person-Centered Service Plan,

(3) Closed Loop Referrals,

(4) HRSN Service Provider qualifications,

(5) Contractor payment to HRSN Service Providers,

(6) HRSN data collection and reporting, and

(7) Coordination with other programs.

b. General Requirements. Contractor shall develop and implement HRSN Services systems that are supported by written policies and procedures (**"HRSN P&Ps"**) that describe the process for the delivery of HRSN Services, including the processes for: (i) conducting HRSN Outreach and Engagement, (ii) identifying HRSN Connectors that will inquire with individuals and make an HRSN Request if the individual expresses interest in receiving HRSN Services, (iii) conducting HRSN Eligibility Screenings to determine HRSN Eligibility and Service need, (iv) authorizing or denying HRSN Services, and (v) making Closed Loop Referrals in accordance with the requirements set forth in this Sec. 15, in Sec. 16 below, and in OARs 410-120-2000[30] through

[30] This existing OAR will be updated effective 1/1/2026.

410-120-2030.[31] Contractor's HRSN P&Ps must at all times reflect current program requirements. Accordingly, Contractor shall promptly update its HRSN P&Ps each time there is a material change to the HRSN Services program as reflected in HRSN related OARs or Contract terms. Contractor's HRSN P&Ps must specifically include a description of all of the elements included in Secs. 15 and 16.

c. **HRSN Services.** HRSN Services are comprised of Nutrition-Related Supports, Housing-Related Supports, and HRSN Outreach and Engagement Services. HRSN Services are provided to Members who belong to an HRSN Covered Population and for whom such services are Clinically Appropriate as a component of health services treatment or prevention. Contractor shall deliver all HRSN Services in compliance with this Contract and as set forth in OARs 410-120-2000 through 410-120-2030, the HRSN Guidance Document, and Contractor's HRSN P&Ps.

(1) **Nutrition-Related Supports** are comprised of four (4) different service categories as follows: (i) Medically Tailored Meals, including assessment for Medically Tailored Meals, (ii) Nutrition Education, (iii) Fruit and Vegetable Benefit, and (iv) Pantry Stocking Benefit (each of the foregoing is an "**HRSN Nutrition Service Category**"). The Nutrition-Related Supports that provide the Pantry Stocking Benefit and the Fruit and Vegetable Benefit will be implemented after January 1, 2026, on a date that has yet to be identified. Contractor shall implement and begin providing Nutrition-Related Supports ninety (90) days after OHA provides Contractor with prior written notice of the date of implementation, which will be made via Administrative Notice. In the event additional, material information regarding the Nutrition-Related Supports is provided or made available to Contractor after such notice has been provided to Contractor, OHA will notify Contractor, via Administrative Notice, of a new implementation date that is at least ninety (90) days from the original implementation date.

(a) Each HRSN Nutrition Service Category is comprised of the specific supports, activities, tasks, and assistance, and the respective scope, amount, and limits, as well as duration for each are set forth in OAR 410-120-2005.[32]

(b) Member eligibility criteria for each specific HRSN Nutrition Service Category are set forth in OAR 410-120-2005.

(c) HRSN Service Provider qualifications for each HRSN Nutrition Service Category are also identified in OAR 410-120-2030.

(d) Assessment for Medically Tailored Meals is not subject to Prior Authorization in order for a HRSN Authorized Member to receive the service. Contractor should pursue coverage and payment for the assessment as an existing Medicaid State Plan benefit when possible. If a Member's assessment for Medically Tailored Meals cannot be covered and paid for under the Medicaid State Plan benefit, it should be covered and paid for under HRSN.

(2) **Housing-Related Supports** is defined in OAR 410-120-0000[33] and is comprised of nine (9) different service categories, which are summarized as follows: (i) rent and utilities financial assistance (past-due and prospective); (ii) paid hotel and motel stays; (iii) utilities deposits or other one-time utilities costs; (iv) property storage financial assistance

[31] This existing OAR will be updated effective 1/1/2026.
[32] This existing OAR will be updated effective 1/1/2026.
[33] This existing OAR will be updated effective 1/1/2026.

(past-due and prospective); (v) tenancy services (housing stability and planning assistance) payable in 15-minute increments; (vi) tenancy services (housing stability and planning assistance) payable per member per month; (vii) home modifications; (viii) home remediations; and (ix) Home Changes for Health During Extreme Weather (each an "**HRSN Housing Service Category**").

(a) For each of the nine (9) HRSN Housing Service Categories, the specific supports, activities, tasks, and assistance as well as the scope, amount, limits, and duration are set forth in OAR 410-120-2005.

(b) Member eligibility for each specific HRSN Housing Supports Service category is set forth in OAR 410-120-2005.

(c) Category specific HRSN Service Provider qualifications are identified in OAR 410-120-2030.

(3) HRSN Outreach and Engagement. HRSN Outreach and Engagement (**"HRSN O&E"**) Services shall be performed in accordance with OAR 410-120-2005, the applicable terms and conditions of this Contract, and as outlined in Contractor's HRSN P&Ps and the HRSN Guidance Document. As set forth in OAR 410-120-2005, HRSN O&E Services mean the activities performed by HRSN Service Providers or Contractor for the purpose of identifying Members who may be eligible for one or more HRSN Services and supporting their connection to other needed services or benefits.

(a) Contractor shall compensate HRSN Service Providers for providing HRSN O&E Services to Members who are presumed eligible for HRSN Services. Such compensation shall be paid in accordance with Ex. B, Part 2, Sec. 16, Para. p of this Contract. As defined in OAR 410-120-0000, a "Presumed HRSN Eligible Member" is a Member who is:

i. Confirmed to be enrolled in OHP (FFS or a CCO), and

ii. Presumed, as reasonably determined by Contractor or an HRSN Service Provider, to belong to one or more HRSN Covered Populations, and

iii. Presumed, as reasonably determined by Contractor or an HRSN Service Provider, to have one or more qualifying HRSN Social Risk Factor(s), and

iv. Presumed, as reasonably determined by Contractor or an HRSN Service Provider, to have one or more HRSN Clinical Risk Factors.

(b) HRSN O&E Services performed and documented by HRSN Service Providers must include, at a minimum, all the activities specified in Sub-Sub.Paras. (i) – (iii) below, which must be completed during initial service delivery. HRSN O&E Services performed and documented by HRSN Service Providers may also include any or all activities specified in Sub-Sub.Paras. (iv) – (x). Subsequent service delivery may include performance and documentation of any or all activities specified in Sub-Sub.Paras. (i) – (x).

i. Engaging Members who may be eligible for HRSN Services. Engagement activities may use multiple strategies, including, without limitation, meeting Members in-person, including travel time as may be necessary.

ii. Identifying and verifying the Member's CCO enrollment or, as applicable, enrollment in the FFS program.

iii. Verifying the Member is Presumed HRSN Eligible.

iv. Transmitting HRSN Requests to the applicable CCO or, as applicable, to OHA.

v. Working with Members to obtain the information necessary to determine HRSN service need, including through multiple engagements.

vi. Helping Members maintain enrollment in OHP.

vii. Helping Members, with securing and maintaining entitlements and benefits, such as Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and other federal and state housing programs including through application assistance and providing support in identifying coverage for application fees, as necessary.

viii. Assisting Members, with obtaining identification and other required documentation needed to receive benefits and other supports (e.g., Social Security card, birth certificate, prior rental history).

ix. Connecting Members, to settings where basic needs can be met, such as access to shower, laundry, shelter, and food.

x. Providing Members, who may have a need for medical, peer, social, educational, legal, and other related services with information and logistical support necessary to connect to resources.

(c) Travel time is billable by HRSN Service Providers carrying out the activities listed in Para c, Sub.Para. (3), Sub-Sub.Para. (b) above of this Sec. 15, Ex. B, Part 2, Sec. 15. Travel time is covered when it is directly to or from the Member's location and/or directly to or from the meeting place to coordinate directly with the Member's care team or on the Member's behalf, as set forth in OAR 410-120-2005. Other travel time is not covered.

(d) Documentation of the activities in Para c, Sub.Para. (3), Sub-Sub.Para. (b) above of this Sec. 15, Ex. B, Part 2~~, Sec. 15~~, including attempts to contact the Member, outcomes, and follow up, is billable time for HRSN Service Providers so long as the time spent documenting for each unique Member is at least eight (8) minutes (one billable unit) for one date of service.

(e) In accordance with Ex. B, Part 2, Sec. 16, Para. p, Sub.Para (4) of this Contract, the Administrative Payments made to Contractor includes sums allocated to HRSN Outreach and Engagement Services when Contractor (or its Subcontractor) performs these services.

(f) HRSN O&E Services performed by Contractor (or its Subcontractor) may include completion of any of the following activities:

i. Engaging Members who may be eligible for HRSN Services. Engagement activities may use multiple strategies, including, without limitation, meeting Members in-person;

ii. Working with Members to obtain the information necessary to determine HRSN Service need, including through multiple engagements;

iii. Helping Members with securing and maintaining entitlements and

benefits, such as TANF, WIC, SNAP, and other federal and state housing programs including through application assistance and providing support in identifying coverage for application fees, as necessary;

iv. Assisting Members with obtaining identification and other required documentation needed to receive benefits and other supports (e.g., Social Security card, birth certificate, prior rental history);

v. Connecting Members to settings where basic needs can be met, such as access to shower, laundry, shelter, and food; and

vi. Providing Members who may have a need for medical, peer, social, educational, legal, or other related services with information and logistical support necessary to connect them with the needed resource(s) and service(s).

(g) The costs associated with travel time for performing the HRSN O&E Services described in Para c, Sub.Para. (3), Sub-Sub.Para. (f) above of this Sec.15, Ex. B, Part 2, are built into the administrative fee paid by OHA to Contractor pursuant to Ex. B, Part 2, Sec. 16, Para. o. and are not separately billable.

(h) HRSN O&E Services are not subject to Prior Authorization, nor is Prior Authorization required for an HRSN Service Provider to invoice and receive payment. Accordingly, Contractor and HRSN Service Providers may provide HRSN O&E Services to Presumed HRSN Eligible Members and subsequently invoice therefor without obtaining Prior Authorization. HRSN O&E Services are limited to thirty (30) hours per member, for twelve (12) months from the initial date of the service, per Contractor.

d. Identifying Members Potentially Eligible for HRSN Services. Contractor shall ensure multiple pathways for Members to be identified as potentially eligible for HRSN Services as described in OAR 410-120-2005. Pathways for identifying potentially eligible Members for HRSN Services at a minimum must include the following:

(1) Proactively identifying Members who can be Presumed HRSN Eligible through a review of Contractor's encounter and claims data;

(2) Contracting with HRSN Service Providers to conduct HRSN O&E to identify Members;

(3) Engaging with and receiving HRSN Requests (outlined in OAR 410-120-2010[34]) from HRSN Connectors (defined in OAR 410-120-0000), including HRSN Service Providers;

(4) Regardless of whether a contractual relationship exists, conducting proactive outreach to HRSN Service Providers, especially HRSN Housing Service Providers, for the purpose of encouraging communication with Members who may be eligible for and benefit from HRSN Services; and

(5) Accepting Members' Self-Attestations or referrals in accordance with OAR 410-120-2015.[35]

(6) Contractor may scale up or down its Member identification efforts, which are described in Sub.Paras. (1) – (5) above of this Para. d, if the Member self-referral or Self-

[34] This existing OAR will be updated effective 1/1/2026.
[35] This existing OAR will be updated effective 1/1/2026.

Attestation described in Sub.Para. (5) results in sufficient numbers of HRSN Eligible individuals requesting and being screened for HRSN Services.

e. **HRSN Service Requests.** In accordance with OAR 410-120-2010, Contractor shall accept and document all requests for HRSN Services **("HRSN Request(s)")** received through the pathways identified in Para. d above of this Sec. 15. Contractor shall accept, document, and receive all Self-Attestations for HRSN Services in the same manner as HRSN Requests.

(1) Contractor shall not require an HRSN Connector to use a particular form or template to make the HRSN Request; instead, Contractor shall accept any HRSN Request used by the HRSN Connector (including the HRSN Request Form made available by OHA on the CCO Contract Forms Website) that complies with the requirements in OAR 410-120-2010 that are applicable to the type of HRSN Connector.

(2) Contractor shall accept HRSN Requests by any delivery method used by HRSN Connectors, including, but not limited to email, fax, mail, personal delivery, CIE, or any other reliable delivery method. For HRSN Connectors who are not HRSN Service Providers, delivery method may also include telephone.

f. **Screening Members for HRSN Eligibility Absent Self-Attestation.** Contractor shall make good faith efforts to ensure all individuals who are the subject of an HRSN Request, through one of the pathways set forth in Para. d above of this Sec. 15 or through any other reliable pathway, are offered an HRSN Eligibility Screening in accordance with OAR 410-120-2015.

(1) Contractor shall first confirm OHP enrollment and, if confirmed, ensure such Member is enrolled with Contractor prior to proceeding with a full HRSN Eligibility Screening. If the Member is not enrolled with Contractor, Contractor shall then ensure the Member is connected with the applicable CCO or, if enrolled in OHA's FFS Program, to OHA, for the purpose of participating in HRSN Eligibility Screening.

(2) Once Contractor confirms the individual who is the subject of the HRSN Request is enrolled with Contractor, Contractor shall use reasonable efforts to obtain all other information necessary to complete the HRSN Eligibility Screening. Contractor's reasonable efforts shall include, without limitation, using the information included in Contractor's own records, obtaining only the relevant information from the Member, and when permitted by the Member, obtaining the relevant and appropriate information from the HRSN Connector.

(a) If the HRSN Connector does not include the information necessary for determining whether the Member is eligible for the requested HRSN Service, Contractor is required to identify the specific HRSN Service the Member needs using the strategies enumerated in Sub.Paras. (1) and (2) above in this Para. f.

(3) Contractor shall document its attempts to collect the information needed to determine eligibility.

(4) Contractor shall document the results of the HRSN Eligibility Screening, which must include, at minimum, all of the following information listed below in this Sub.Para. (4):

(a) Ensuring the Member is enrolled in OHP Plus (BMH Benefit Package Identifier) including the Member's OHP ID number;

(b) The HRSN Service requested, and whether the source of the HRSN Request was, (i) Member self-referral/attestation, (ii) Member or their Representative, (iii)

HRSN Connector (other than an HRSN Service Provider), (iii) HRSN Service Provider, or (iv) direct outreach from Contractor;

(c) The HRSN Covered Population to which the Member belongs;

(d) The Member's HRSN Clinical Risk Factor(s) applicable to the requested HRSN Service as set forth in OAR 410-120-2005;

(e) The Member's HRSN Social Risk Factors, as applicable to the requested HRSN Service as set forth in the in OAR 410-120-2005;

(f) The Member's HRSN Services authorized (or denied);

(g) All other eligibility criteria and required documentation that may be applicable to the requested HRSN Service as set forth in OAR 410-120-2005; and

(h) Confirmation or a determination that the Member is not receiving the same service as the requested HRSN Services from a local, state, or federally funded program, based on existing documentation or Member attestation.

i. If the Member is receiving a similar service as the HRSN Service requested, the HRSN Service may be provided to an Authorized Member to fill gaps or otherwise supplement current program, but in no event shall a Member be authorized to receive duplicate existing services.

(5) On a quarterly basis and as OHA may reasonably request from time to time, Contractor shall submit the information listed in Para. f, Sub.Para. (4), Sub-Sub.Paras. (a) – (f) above of this Ex. B, Part 2, Sec. 15 to OHA in the applicable deliverables as follows:

(a) Information identified in Sub-Sub.Paras. (b) and (c) shall be reported in the Social Needs Service Coordination Report.

(b) Information identified in Sub-Sub.Paras. (d) and (e) shall be reported in the Grievance and Appeal Log and in Exhibit L reporting.

(c) Information identified in Sub-Sub.Para. (f) shall be reported in the Grievance and Appeal Log.

(d) Information identified in Sub-Sub.Para. (a) shall be reported in all reports and logs.

(6) Contractor shall comply with all HRSN Eligibility Screening reporting requirements as specified in the HRSN Guidance Document and applicable OARs, including OAR 410-120-2015.

(7) Contractor must re-assess YSHCN Members for HRSN Eligibility at least annually for as long as the member remains a YSHCN Member.

g. HRSN Eligibility Screening with Self-Attestation. Prior to authorizing or denying HRSN Services for a Member who submits a Self-Attestation, Contractor shall first complete the HRSN Eligibility Screening by documenting the information identified in Sub.Para. (4) above in Para. f of this Sec. 15 that the Member included in their Self-Attestation. Contractor shall also, prior to authorizing or denying HRSN Services for a Member who submits a Self-Attestation, use good faith efforts to verify a Member's Self-Attestation within a reasonable period of time in accordance with OAR 410-120-2015.

(1) If Contractor cannot, using good faith efforts, verify the Member's Self-Attestation, within a reasonable period of time, Contractor shall, if it determines in its reasonable

discretion the Self-Attestation is truthful, authorize the identified HRSN Services need. Contractor shall document its good faith efforts to verify the Member's Self-Attestation and the reasonable basis for authorizing the HRSN Services.

(2) In no event will Contractor be liable to OHA or the State for authorizing HRSN Services nor will OHA or the State take any adverse action against Contractor based on Contractor's acceptance of a Self-Attestation provided the authorization was made in accordance with Sub.Para. (1) above of this Para. g. However, failure to document the information as required under Sub.Para. (1) above of this Para. g, may result in liability to OHA.

(3) If Contractor obtains information during the good faith verification process that invalidates the Member's HRSN Self-Attestation, Contractor shall not authorize the delivery of HRSN Services. Such denial and the reason thereof shall be documented.

h. Authorization of HRSN Services.

(1) If, after completing the HRSN Eligibility Screening in accordance with OAR 410-120-2015, Contractor determines the Member meets all of the criteria for being HRSN Eligible, Contractor shall authorize the identified HRSN Services in accordance with OARs 410-141-3835 and 410-120-2020.[36]

(2) If, after completing the HRSN Eligibility Screening in accordance with OAR 410-120-2015, Contractor determines the Member does not meet all of the criteria for being HRSN Eligible, Contractor shall deny the delivery of HRSN Services as expeditiously as possible in accordance with OARs 410-141-3835 and 410-120-2020. Contractor shall document the reason for the denial.

(3) The Authorization must identify service duration, which must be Clinically Appropriate. In no event shall the duration of an HRSN Service Authorization exceed twelve (12) months except Tenancy Services, which may not exceed eighteen (18) months. However, if Clinically Appropriate, service duration of an HRSN Service Authorization may be less as set forth in OAR 410-120-2020(3) and the applicable tables in OAR 410-120-2005, as well as amount and scope in accordance with 42 CFR 438.210.

(4) Contractor shall require clinical staff to review HRSN Service denials or reductions in scope, amounts, or duration requested in accordance with OAR 410-120-2020.

(5) In accordance with Ex. B, Part 2, Sec. 3, Para. b, Sub.Para. (2) and 42 CFR 438.210(b)(3), clinicians who review decisions to deny or reduce the scope, amount or duration of an HRSN Service must have appropriate expertise in addressing the Member's HRSN needs.

(6) Contractor must document the approval, denial, or reduction or HRSN Services.

(7) Contractor shall notify the HRSN Connector who submitted the HRSN Request of the approval or denial of the HRSN Request if the HRSN Connector will be or would have been an HRSN Service Provider or was the HRSN Service Provider who conducted HRSN O&E Services.

(8) #Members who have been screened and authorized to receive, and have received, HRSN Services must not be rescreened for the same HRSN Services except as follows:

[36] This existing OAR will be updated effective ~~9/1/2025 for Enrolled Oregon Senate Bill 690 (2025) and again effective~~ 1/1/2026 ~~according to OHA's cadence for regular annual updates~~.

(a) The Member was screened but not authorized for the HRSN Service, but their circumstances have since changed.

(b) The Member was screened and authorized for the HRSN Service, but they never received the approved HRSN Service.

i. Authorization or Denial of HRSN Services: Additional Requirements.

(1) In the event Contractor uses technology (e.g., CIE) for Closed Loop Referrals (i.e., refer an HRSN Authorized Member to an HRSN Service Provider):

(a) Contractor must notify Members that they have the right to opt out of technology (e.g., CIE) for Closed Loop Referrals and still receive HRSN Services. If a Member opts out of technology, the Member's election to opt-out must be documented and Contractor must also notify the applicable HRSN Service Providers of such Member's election to opt out of technology.

(b) Contractor shall notify the HRSN Connector who submitted the HRSN Request of the approval or denial of the HRSN Request if the HRSN Connector will be or would have been the HRSN Service Provider.

(2) Contractor shall, to the extent there is a choice of HRSN Service Providers where the HRSN Authorized Member is located, support the Member's choice of HRSN Service Provider provided that the Member's preferred HRSN Service Provider has the resources to provide such Member's HRSN Service need.

(3) All authorizations of HRSN Services must be Clinically Appropriate (as such term is defined in OAR 410-120-0000) for the Member's HRSN Social and Clinical Risk Factors that were identified (and documented) during the Member's HRSN Eligibility Screening. In addition, all HRSN Service Authorizations must, in accordance with 42 CFR § 440.210 identify the scope, amount, and duration (initial authorization not to exceed 12 months or a lesser duration if required according to OAR 410-120-2020) as is Clinically Appropriate for the HRSN Authorized Member, with the exception of Tenancy Services which may not exceed eighteen (18) months.

(4) Contractor shall document whether a Clinically Appropriate service duration limitation may be extended by rescreening the previously HRSN Authorized Member in accordance with this Sec. 15.

(5) In accordance with Sec. 2 above of this Ex. B, Part 2 and 42 CFR § 438.210, Contractor shall ensure the HRSN Services are sufficient in the amount, duration, and scope necessary to achieve, as reasonably expected, the purpose for which the HRSN Services are furnished.

(6) As provided for in Para. c, Sub.Para. (3) above of this Sec. 15, HRSN Service Providers are eligible to receive payment for HRSN Outreach and Engagement Services only when provided to Members who are either (i) Presumed HRSN Eligible as describe in Sub.Para. (3) of Para. c of this Sec. 15, or (ii) have already been determined eligible and have been referred by Contractor to an HRSN Service Provider for the purpose of receiving HRSN O&E Services.

(7) In accordance with Sec. 2 above of this Ex. B, Part 2 and 42 CFR Part 456 must comply with and employ utilization management policies, procedures, and criteria for HRSN Services.

(8) OHA will not take adverse action against Contractor for authorizing HRSN Services for a Member later determined ineligible due to receipt of duplicative services so long as the determination was made in accordance with State guidance and was reasonable given the information available to Contractor at the time the determination was made.

j. Notification of HRSN Services Authorization, Denial, or Delay. Contractor shall notify all Members who have undergone HRSN Eligibility Screening of the HRSN Service authorization or denial as expeditiously as the circumstances require, in accordance with OARs 410-141-3835 and 410-120-2020.

(1) Service authorizations and associated timelines are not applicable to Members who are only receiving HRSN O&E Services. The content of all such notices shall comply with Sub.Paras. (11) or (12) as applicable, Para. b of Sec. 3 above of this Ex. B, Part 2.

(2) Members who are denied HRSN Services have Grievance and Appeal rights. Members also have Grievance and Appeal rights if the authorized HRSN Service(s) are limited in scope, amount, or duration from what was requested. Accordingly, Contractor shall comply with the Grievance and Appeal processes outlined in Ex. I, "Grievance and Appeal System" of this Contract.

16. Health-Related Social Needs Services: Administrative and Delivery Processes; HRSN Service Delivery Network Requirements

a. Contractor's Obligations After HRSN Service Authorization. Upon authorization of HRSN Services, Contractor shall refer the HRSN Authorized Member to the HRSN Service Provider or HRSN Service Vendor for the approved HRSN Service through a Closed Loop Referral (except for Home Changes for Health or situations where Contractor is the only willing and qualified organization capable of providing the HRSN Service in accordance with OAR 410-120-2000).

(1) In accordance with OARs 410-141-3860 through 410-141-3870, Contractor is responsible for ensuring HRSN Service Providers or HRSN Service Vendors deliver the HRSN Services to all HRSN Authorized Members referred thereto in accordance with each applicable HRSN Person-Centered Service Plan (as such plan is required under Para. m below of this Sec. 16).

(a) In the event an HRSN Service Provider or HRSN Service Vendor fails to deliver the HRSN Services as required, Contractor shall assign the affected HRSN Authorized Member with a new, alternative HRSN Service Provider or HRSN Service Vendor that is capable of providing the necessary, authorized HRSN Services as expeditiously as possible.

(2) After HRSN Service authorization, Contractor shall make a referral to an HRSN Service Provider or HRSN Service Vendor that is capable of delivering the authorized HRSN Service(s) and ensure that the service is delivered as expeditiously as the Member's circumstances requires in accordance with OAR 410-120-2020.

(3) Contractor must expressly require all HRSN Service Providers to provide Contractor with written notification of their acceptance or declination of each HRSN Authorized Member referred to the HRSN Service Provider (i.e., Closed Loop Referrals). HRSN Service Providers must provide Contractor with the required notice within a reasonable period of time in light of the circumstances giving rise to the HRSN Services need.

(4) Contractor must expressly require all HRSN Service Providers to provide to Contractor, for each HRSN Authorized Member referred, written notification of when HRSN

Services were provided or the date on which the HRSN Service Provider determined the HRSN Services could not be provided, and the reason why such Services could not be provided.

(5) Contractor must expressly require all HRSN Service Providers to document the date, time, duration, outcome, and description of the HRSN O&E Services and HRSN Tenancy Services.

(6) OHA shall not compensate Contractor or any of Contractor's HRSN Service Providers for the delivery of HRSN Services, unless the Member meets all eligibility criteria at the time the HRSN Service is delivered to the Authorized Member; therefore, in accordance with OAR 410-120-1140, eligibility and benefit coverage must be verified before the delivery of any authorized HRSN Service, whether the HRSN Service is a one-time occurrence or is comprised of multiple deliveries over a period of time.

b. Support of Closed Loop Referrals. Contractor shall:

(1) Develop a plan to support Closed Loop Referrals as detailed in the HRSN Guidance Document.

(2) Develop a plan to support and incentivize HRSN Service Providers to adopt and use technology for Closed Loop Referrals such as, but not limited to: (i) developing and awarding grants, (ii) providing technical assistance, (iii) conducting outreach and education, and (iv) engaging HRSN Service Providers in providing feedback. Contractor must report on progress made on the plan in its annual CCO HIT Roadmap as required.

(3) Contractor must ensure compliance with reporting requirements for Closed Loop Referrals as defined and specified by OHA in OAR 410-120-2020 and the HRSN Guidance Document.

(4) Contractor may require HRSN Service Providers to use technology (e.g., CIE) to conduct Closed Loop Referrals for HRSN Services. In the event Contractor requires HRSN Service Providers to do so, Contractor must:

(a) Allow for exceptions to any requirements for technology (e.g., CIE) for Closed Loop Referrals for HRSN Service Providers who are unable to participate. Exceptions must align with guidance provided by OHA.

(b) Report on any requirements and exceptions process for technology (e.g., CIE) for Closed Loop Referrals, as described in Ex. J, Part 2.

(c) Report on specific HRSN Service Providers who requested an exception to use technology for Closed Loop Referrals (e.g., CIE) and the outcome of that request. OHA will make reasonable efforts to incorporate reporting into other existing reports required under this Contract. In the event reporting requirements cannot be included in an existing report required to be submitted under another provision of this Contract, OHA shall provide Contractor with an HRSN specific reporting template at least ninety (90) days prior to the due date of the report.

c. HRSN Policies and Procedures. By no later than February 3, 2026, Contractor shall develop or update (or both) its HRSN Services policies and procedures to address all elements of the HRSN Services as set forth in Sec. 15 above and this Sec. 16 of this Ex. B, Part 2 as well as the HRSN Guidance Document ("HRSN P&Ps"). Contractor shall submit its HRSN P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

d. **Readiness Plans.** Contractor submitted separate HRSN Readiness Plans to OHA for HRSN Home Changes for Health During Extreme Weather and HRSN Housing-Related Supports in compliance with the applicable terms and conditions of this Contract during Contract Year five (2024) and for Nutrition-Related Supports in Contract Year six (2025). OHA reserves the right to require Contractor to submit a new or revised HRSN Readiness Plan(s) in the event of changes to HRSN Eligible Populations, HRSN Services, and any other material changes to the HRSN Services program. Contractor shall draft an HRSN Readiness Plan for the new HRSN Nutrition-Related Supports ("Nutrition Readiness Plan") being implemented in Contract Year seven (2026) – Fruit and Vegetable Benefit and Pantry Stocking Benefit – and submit such Plan to OHA via Administrative Notice by no later than February 3, 2026.

(1) Contractor shall use the Readiness Plan template(s) to document Contractor's readiness to provide the new HRSN Nutrition-Related Supports (Fruit and Vegetable Benefit and Pantry Stocking Benefit). The HRSN Readiness Plan template(s) is posted on the CCO Forms Website.

(2) Contractor's HRSN Nutrition Readiness Plan shall address each of the elements specified in the Nutrition Readiness Plan requirements provided on the CCO Contracts Forms Website. Such elements may include those identified in (a) – (g) below of this Sub.Para. (2), Such elements may be subject to change and in such event, the changes will be reflected in the Nutrition Readiness Plan requirements made available on the CCO Contract Forms Website:

(a) Attestation of compliance,

(b) Service Authorization standards,

(c) Pre-identification of the Members,

(d) Delivery of Services (including available service capacity information and number of Members Contractor estimates it will provide HRSN Services to annually),

(e) Payment method,

(f) Conflict of interest protections, and

(g) Any other documentation that may be reasonably requested by OHA (as described in Sub.Para. (4) below of this Para. d).

(3) OHA will provide additional information about HRSN Nutrition Readiness Plan requirements on the CCO Contract Forms Website prior to the date on which Contractor is required to commence providing HRSN Nutrition-Related Supports under this Contract. In the event the additional information is not posted at least ninety (90) days prior to the date on which Contractor's HRSN Nutrition Readiness Plan is required to be submitted to OHA, OHA will notify Contractor, via Administrative Notice, of a new due date for such Readiness Plan that is at least ninety (90) days from the date of posting.

(4) OHA will review Contractor's HRSN Nutrition Readiness Plan and provide Contractor with written notice of either (i) its approval, or (ii) its request for additional detail, or an on-site review (or both).

e. **Access to HRSN Services**

(1) Contractor shall provide Culturally and Linguistically Appropriate HRSN Services in accordance with Ex. B, Part 4, Sec. 2, "Access to Care."

(2) Contractor shall ensure HRSN Services are accessible to HRSN Authorized Members, which includes ensuring that HRSN Service Providers have the operating hours and the staff necessary to meet HRSN Authorized Member needs.

(3) OHA reserves the right to require Contractor to submit to OHA in writing any barriers Members face accessing HRSN Services and draft a strategic plan for removing such barriers in accordance with Para. b of Ex. B, Part 4, Sec. 2.

(4) Contractor shall, in accordance with Para. d of Ex. B, Part 4, Sec. 2, ensure that HRSN Service Providers do not discriminate in the provision of HRSN Services, including hours of operation to Contractor's Members, OHA's Fee-for-Service Members, and individuals who are not enrolled in OHP but to whom the HRSN Service Provider also provides the same or substantially similar services.

(5) Contractor shall comply with the requirements of Title III of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring denials, approvals and delivery of, and communications about HRSN Services to Members with diverse cultural and ethnic backgrounds including through interpreter services, in accordance with Para. h of Ex. B, Part 4, Sec. 2.

(6) Contractor shall maintain written policies, procedures, and plans relating to the communication about and delivery of HRSN Services in compliance with Para. i of Ex. B, Part 4, Sec. 2.

(7) Contractor shall comply with the requirement of Title III of the Americans with Disabilities Act by ensuring that HRSN Services provided to Members with disabilities are provided in appropriate, integrated settings, in accordance with Para. j of Ex. B, Part 4, Sec. 2.

(8) Contractor shall ensure that its employees, Subcontractors, and facilities are able to meet the HRSN Service needs of Members who require accommodations due to disability or limited English proficiency, in accordance with Para. k of Ex. B, Part 4, Sec. 2.

(9) Contractor shall develop a methodology for evaluating access to HRSN Services in accordance with Para. l of Ex. B, Part 4, Sec. 2; however, Contractor's network of HRSN Service Providers is not subject to quantitative metric requirements as described in OAR 410-141-3515.

(10) In the event Contractor is unable to provide local access to HRSN Services, Contractor must use its best efforts to provide reasonable alternatives to care.

f. HRSN Delivery System and Provider Capacity

(1) Contractor shall maintain and Monitor an HRSN Service Provider Network that (i) is supported with written agreements, and (ii) has sufficient capacity and expertise to provide adequate access to HRSN Services in a reasonable period of time and in accordance with Para. a, Sub.Para. (1) of Ex. B, Part 4, Sec. 3, "Delivery System and Provider Capacity."

(2) Contractor shall ensure that all Members have access to an HRSN Service Provider Network that meets the HRSN Services needs of Members in accordance with Para. a, Sub.Para. (2) of Ex. B, Part 4, Sec. 3.

(3) In establishing and maintaining its HRSN Service Provider Network, Contractor shall develop and implement a methodology to establish and Monitor capacity, in accordance with all factors outlined in Para. a, Sub.Para (2) of Ex. B, Part 4, Sec. 3.

(4) Contractor shall ensure that HRSN Services Providers meet cultural responsiveness and linguistic appropriateness needs of Members in accordance with Para. a, Sub.Para. (7) of Ex. B, Part 4, Sec. 3.

g. HRSN Service Provider Selection

(1) Contractor shall establish and maintain an HRSN Service Provider network in accordance with Para. a of Ex. B, Part 4, Sec. 4, "Provider Selection," except that:

(a) Contractor's network of HRSN Service Providers is not subject to quantitative metric requirements as described in OAR 410-141-3515.

(2) Contractor shall ensure that all HRSN Service Providers meet the qualifications set forth in OAR 410-120-2030 on or before they begin providing HRSN Services, which include, without limitation ensuring they:

(a) Meet the Specific qualifications for the specific HRSN Services that they provide;

(b) Have demonstrated experience providing culturally and linguistically appropriate, responsive, trauma-informed services;

(c) Are not delegated any responsibility for HRSN Service authorization or service planning.

h. HRSN-Related Credentialing. Contractor shall, for all HRSN Service Providers, comply with all of the credentialing requirements set forth in OARs 410-141-3510 and OAR 410-120-2030.

i. HRSN Subcontract & Contract Requirements. Contractor's relationship with its HRSN Service Providers may meet the definition of Subcontractor as defined in this Contract.

(1) In the event any relationship between Contractor and any of its HRSN Service Provider meets the definition of a Subcontractor, Contractor shall, with respect to such HRSN Service Providers, comply with Sec. 12, "Subcontract Requirements," of Ex. B, Part 4 and any other applicable Subcontractor requirements set forth in this Contract.

(2) In the event any relationship between Contractor and any of its HRSN Service Providers does not meet the definition of a Subcontractor, Contractor shall, notwithstanding the foregoing, comply with the following provisions of Sec. 12, "Subcontract Requirements," of Ex. B, Part 4: Para. a, Sub.Paras. (2), (3), (5), (6), (10), and (11); Para.b, Sub.Para. (1), Sub-Sub.Paras. (e), (f), (g), (i), and (j); Para. b, Sub.Para. (2), and any other provisions that may be identified in the HRSN Guidance Document.

j. HRSN Conflicts of Interest Safeguards. Contractor shall protect against conflicts of interest in the administration and delivery of HRSN Services. All Subcontracts and contracts entered into between Contractor and all of its HRSN Service Providers shall include a provision that prohibits HRSN Service Providers from having any involvement in (i) authorizing or denying any HRSN Service or (ii) service planning for an HRSN Eligible Member. Contractor shall not deliver any HRSN Service that it has authorized unless Contractor can demonstrate it is the only willing and qualified organization that is capable of providing the HRSN Service in the applicable Authorized Member's geographic region in accordance with OAR 410-120-2000.

(1) Contractor must be able to demonstrate to the Authority that it is the only willing and qualified organization that is capable of providing the HRSN Service in the applicable geographic region.

(2) Contractor must devise conflict of interest protections including separation of authorization and HRSN Service Provider functions within Contractor's organization.

(3) The conflict of interest protections devised by Contractor must be documented in a form or format identified by OHA and is subject to the approval of OHA.

k. **HRSN Provider Directory.** Contractor shall include all HRSN Service Providers in Contractor's Provider Directory in accordance with Ex. B, Part 3, Sec. 6. Contractor may utilize Contractor's existing Provider Directory format when adding its HRSN Service Providers to the Provider Directory so long as all HRSN Service Providers are searchable at once.

l. **Public Webpage for HRSN Service Providers.** Contractor shall maintain a public webpage that provides relevant information about how HRSN Service Providers are able to participate in the HRSN program, including relevant HRSN Service Provider qualifications, such that individuals and organizations interested in becoming HRSN Service Providers are able to determine whether they are or may be qualified to become one of Contractor's HRSN Service Providers ("HRSN SP Resource Webpage"). Such public webpage shall also prominently display Contractor's contact information sufficient to assist HRSN Service Providers. Contractor shall update the HRSN SP Resource Webpage by February 3, 2026, with any changes necessary to reflect Contractor's Nutrition-Related Supports and other HRSN Service programs. Contractor shall also update the HRSN SP Resource Webpage within thirty (30) days of any change or new content relating to Contractor's HRSN Services program. If Contractor changes the URL for the HRSN SP Resource Webpage, Contractor shall provide the new URL to OHA, via Administrative Notice, within ten (10) days of the date of change. OHA will post Contractor's URL on a public-facing webpage targeted to HRSN Service Providers that includes information about HRSN Services, including:

(1) Process and qualifications to become an HRSN Service Provider;

(2) Information on invoicing and fee schedules for HRSN Services;

(3) Information on how the HRSN Service Providers can conduct Closed Loop Referrals; and

(4) Clinical and Social Risk Factor criteria that individuals must meet in order to access HRSN Services.

m. **Public Webpage with Information about HRSN Services for Members.** No later than March 1, 2026, Contractor shall provide to OHA, via Administrative Notice, the URL for its public webpage that provides relevant information about how Members are able to request and receive HRSN Services (inclusive of, without limitation, eligibility criteria) and an overview of the process from request to service delivery. The webpage shall also include information about Contractor's availability to assist Members with navigating HRSN program processes. Such information must include the prominent display of the contact information Members may use to obtain the desired assistance. Contractor shall update the webpage within thirty (30) days of any change or new content relating to Contractor's HRSN Services program. If Contractor changes the URL for the webpage, Contractor shall provide the new URL to OHA, via Administrative Notice, no later than ten (10) days after the date of change. OHA will post Contractor's URL on a public-facing webpage targeted to Members that includes information about HRSN Services.

n. **Notification to all Network Providers.** Contractor shall promptly notify all its Network Providers any new HRSN Services that are scheduled to be made available to Members (as such date is identified in the applicable amendment), but in no event shall notice occur more than thirty (30) days after the new HRSN Services are made available to Members. Such notice must also identify the URL for its HRSN SP Resource Webpage.

o. **Reporting on HRSN Service Provider Network.** To the extent the provisions in the authorities identified in Sub.Paras. (1) and (2) below of this Para. o apply to HRSN Service Providers, Contractor shall comply therewith; however, Contractor's network of HRSN Providers is not subject to any quantitative metric requirements including those described in OAR 410-141-3515:

(1) All requirements in Ex. G, Sec. 1, "Delivery System Network (DSN) Provider Monitoring and Reporting Overview."

(2) All requirements in Ex. G, Sec. 2, "Delivery System Network Provider Monitoring and Reporting Requirements" as they relate to HRSN Service Providers.

p. **HRSN Person-Centered Service Plan.** Upon Contractor's authorization of HRSN Services, Contractor and the HRSN Authorized Member shall update the Member's Care Plan as outlined in OAR 410-141-3870, to include an HRSN Person-Centered Service Plan (PCSP) for the Member to obtain the HRSN Service(s) in accordance with OAR 410-120-2025.

q. **Contractor Payment to HRSN Service Providers.** OHA will reimburse Contractor for the provision of covered HRSN Services as set forth below in this Para. q.

(1) **HRSN Fee Schedule.** Contractor shall pay HRSN Service Providers for HRSN Services provided to an HRSN Authorized Member when performed in accordance with this Para. q, and OHA will pay Contractor for the cost of other HRSN Services furnished to HRSN Authorized Members up to the amounts described in the Oregon HRSN Fee Schedule and Methodology Document, which is located at https://www.oregon.gov/oha/FOD/Pages/OHP-Rates.aspx.

(2) **Fees Payable for HRSN Outreach and Engagement Services.** HRSN Service Providers with which Contractor has contracted to provide HRSN O&E shall be compensated for conducting HRSN Outreach and Engagement Services to Members Presumed HRSN Eligible in accordance with Sub.Paras. (3) - (5) of Para. c of Sec. 15 above of this Ex. B, Part 2. The fees payable for providing HRSN O&E Services shall be made in accordance with the HRSN Fee Schedule. All HRSN O&E Services must be documented such that claims for compensation are capable of being verified for purposes of an audit.

(3) **Payment for Home Changes for Health.**

(a) OHA's Capitation Payments to Contractor are inclusive of services and devices provided to HRSN-Authorized Members through the HRSN Housing Service Category referred to as Home Changes for Health. Nonetheless, Contractor is required to meet the obligations for invoicing and reporting set forth in Sub.Para. (4) below of this Para. q for Home Changes for Health service and devices.

(b) Home Changes for Health services and devices are subject to the Risk Corridor specified in Ex. C, Sec. 6 of this Contract.

(c) OHA will include the Capitation Payments and any additional payments to Contractor resulting from the Risk Corridor settlement described in Ex. C, Sec. 6

in the Medical Loss Ratio calculation described in Ex. C, Sec. 10 as incurred claims.

(4) Non-Risk Invoicing Process and HRSN Required Reporting Data.

(5) HRSN Service Providers shall submit invoices and documentation to Contractor for payment for all HRSN Services furnished to HRSN Authorized Members or, in the case of HRSN O&E, even if they are not Authorized for an HRSN Service, for providing HRSN O&E to Members who are Presumed HRSN Eligible. OHA will pay Contractor based on HRSN Services provided and submitted through Contractor's Encounter Data, except for Home Changes for Health services and devices which are included in OHA's Capitation Payments to Contractor as described in Sub.Para. (3) above.

(a) Subject to its discretion, Contractor has the right, but not the obligation, to make interim payments to HRSN Service Providers prior to the delivery of HRSN Services to an HRSN Authorized Member and then reconcile the interim payments that were previously made to the HRSN Service Provider.

(b) Contractor shall process all complete and accurate HRSN Service Provider invoices for HRSN Services provided to HRSN Authorized Members and pay all complete and accurate claims received from HRSN Service Providers in a timely manner consistent with timelines for processing HRSN Service Provider invoices and paying claims for other Covered Services as described in Ex. B, Part 8, Sec. 5 Claims Payment.

i. Invoices must include the documentation of the specific HRSN Service provided. For example, Home Changes for Health device invoices must include the device type. For labor-only invoices for Home Changes for Health, such as when a device is provided by Contractor and installed by Contractor's HRSN Service Provider or HRSN Service Vendor, the device type must be included.

(c) Contractor shall submit to OHA the HRSN specific tabs on Exhibit L, detailing Member level and Provider level reporting data each calendar quarter and as reasonably requested by OHA from time to time.

(d) Contractor shall provide all data, files, and information requested by OHA related to the operationalization and administration of the invoicing processes.

(e) Non-Risk HRSN expenses and revenue will be excluded from Medical Loss Ratio Rebate calculations. However, in the event OHA determines, in its sole discretion, that HRSN Services should be included in the risk-based capitation payments, such payments will be included in the Medical Loss Ratio Rebate calculations as incurred claims. In no event will OHA include HRSN Services in the risk-based capitation payments without providing Contractor with at least sixty (60) days prior written notice.

(6) HRSN Administrative Payments.

(a) OHA will pay Contractor for HRSN administrative services, such as Case Management Services, Care Coordination, HRSN Outreach and Engagement Services, HRSN Eligibility Screening, Provider Network management, Community Capacity Building Funding administration, HRSN Service Provider

payment and claims processing, and Member services. OHA will pay Contractor in two ways:

i. A fixed administrative fee at the CCO Payment Rate specified in Exhibit C-Attachment 1 of this Contract (which is incorporated by reference as though fully set forth in this Sub-Sub.Para. (a), for the administration of covered HRSN Services for Contractor's Members in the CCOA and CCOB Plan Types); and

(7) A variable administrative fee for the following housing services: the first month of rent/temporary housing and utility costs; medically necessary home accessibility modifications; and medically necessary home remediations, based on the HRSN Housing Fee Schedule.

(a) Contractor shall submit HRSN direct administrative supporting documentation in a manner and format defined by OHA ("2026 HRSN Administrative Settlement Template") posted on the CCO Contract Forms Website. The foregoing submission shall be made to OHA via Secure File Transfer Protocol. Administrative expenses will be itemized in guidance for reporting purposes in a format defined by OHA. The foregoing submission shall be made on April 30, 2027, after the close of the rating period, January 1, 2026, through December 31, 2026.

(8) OHA will review Contractor's report on HRSN administrative expenses described in Sub-Sub.Para. (b) above of this Sub.Para. (5) and notify Contractor of any identified errors or concerns. This review may include a comparison to HRSN administrative funding, total administrative funding for all OHA programs, OHA's Third-Party Contractor HRSN administrative funding, and a relativity to volume of HRSN Services administered. This review may include: (i) consideration for each CCO individually and all CCOs collectively; (ii) a comparison to Encounter Data or other reports (or any combination thereof) to validate the accuracy of Contractor's reporting; and (iii) other considerations and comparisons. In the event OHA identifies any errors or has concerns as a result of its review, OHA shall have the right to request, and Contractor shall be required to submit, a revised report or make adjustments to Contractor's report as deemed necessary by OHA in its sole discretion. Any such revised or adjusted report must be provided to OHA within ten (10) Business Days after the date of request, which OHA will make via Administrative Notice.

(9) HRSN administrative payments are subject to the Risk Corridors specified in Ex. C of this Contract. OHA has established a separate Risk Corridor for each of HRSN Home Changes for Health-Related Supports, HRSN Housing-Related Supports, and HRSN Nutrition-Related Supports. For HRSN O&E Services, OHA has not established a separate Risk Corridor. Instead, OHA will allocate expenses for HRSN O&E Services to the other three HRSN Services based on the relative expense of each of those HRSN Services.

(10) In accordance with 42 CFR § 447.362(b), OHA's total HRSN administrative payments to CCOs, inclusive of payments made or owed under the applicable Risk Corridor, will not exceed the net savings of administrative costs OHA achieves by contracting with Contractor.

i. The HRSN administrative services payments may be retroactively adjusted per CMS rule if they exceed:

A. The percent of direct service costs equivalent paid to OHA's Third-Party Contractor to administer HRSN Covered Services to the OHA's Medicaid FFS enrollees for the calendar year; and

B. Any additional HRSN direct administrative expenses incurred directly by OHA in the operation of the HRSN program for the calendar year, calculated as a percent of direct service costs.

(11) OHA will evaluate the final increase or decrease to the initial Risk Corridor calculation based on the information received from Contractor and in accordance with 42 CFR § 447.362(b). In the event OHA determines a decrease in HRSN administrative payments is required to comply with 42 CFR § 447.362(b), OHA will decrease the HRSN administrative payments made to all CCOs to the extent necessary such that the total sum of all HRSN administrative payments made to all CCOs is less than the net savings of administrative costs OHA achieves by Contracting with CCOs.

(12) Encounter Data Submission and Validation.

(a) Contractor shall submit Encounter Data by the date specified in the Administrative Notice for all HRSN Services in accordance with Ex. B, Part 8, Secs. 11 through 13 of this Contract. OHA retains the right to validate all Encounter Data. All Encounter Data for HRSN Services, including payments made by Contractor, that is submitted using the process set forth in Sub.Para. (3) above of this Para. p will be compared by OHA against Contractor's Ex. L reporting.

(b) Material discrepancies, as determined by OHA in its sole discretion, must be resolved by Contractor, and OHA will work with Contractor to reconcile such discrepancies. In accordance with Ex. D, Sec. 7 of this Contract, and without limiting any other rights and remedies OHA may have under this Contract and at law or equity, OHA has the right to recover any Overpayments made for HRSN Services. OHA has the sole and exclusive authority to decide when any reporting discrepancies are adequately resolved. OHA has the right to withhold payments to Contractor for amounts in dispute and shall not be charged interest on any payments so withheld.

(13) CMS Requirements. The payment process for HRSN Services shall comply with all applicable CMS regulations, guidance, and other applicable requirements (e.g., approved HRSN Service Protocol) which includes 42 CFR §447.362 relating to non-risk managed care contracts. OHA's payments to Contractor are contingent upon CMS approval and provision of federal matching funds. Contractor shall provide to OHA any supporting information or data (or both) requested by OHA as is necessary for OHA to adequately respond to inquiries from CMS.

(14) Subcontractor Requirements. If an HRSN Service Provider is also a Subcontractor of Contractor, then the provisions set forth in Ex. B, Part 4, Sec. 12 of this Contract are applicable to such Contractor-Subcontractor relationship. Accordingly, Contractor and Subcontractors are compensated for HRSN O&E Services through the HRSN administrative payments, and they are not eligible for separate compensation for HRSN O&E Services under the HRSN Fee Schedule.

r. **Community Capacity Building Funds.** Contractor must enter into and maintain a grant agreement with OHA specific to the Community Capacity Building Funds ("CCB Funds"). OHA shall disburse CCB Funds in accordance with such grant agreement. Contractor shall:

(1) Be responsible for the distribution and administration of the HRSN Capacity Building Funding to community-based organizations to enable them to become HRSN Service Providers;

(2) Ensure the distribution and management of HRSN Capacity Building Funding is part of Contractor's administrative and network responsibilities; and

(3) Ensure compliance with the reporting requirements specific to Community Capacity Building Funding as defined by OHA.

s. **HRSN Guidance Document; Compliance with Reporting Requirements.** Contractor's reporting requirements as set forth in the HRSN Guidance Document (located on the CCO Contract Forms Website) as they may be updated from time to time, are incorporated by reference as though fully set forth in this Para. s.

(1) Accordingly, and without limiting Contractor's obligation to comply with any and all other reporting requirements in this Contract and as may additionally be required under Applicable Law, Contractor must comply with all HRSN reporting requirements in the HRSN Guidance Document relating to (i) HRSN Member Identification, (ii) HRSN Requests, (iii) HRSN Authorizations, Denials, Grievances and Appeals, (iv) HRSN financial information, (v) HRSN O&E Services, (vi) Closed Loop Referrals, HRSN Person-Centered Service Plans, and Care Coordination, and (vii) HRSN Provider Network. HRSN Reports shall be submitted to OHA as specified in the HRSN Guidance Document or as detailed in any Administrative Notice.

(2) OHA will make reasonable efforts to incorporate HRSN Services reporting into other existing Reports required under this Contract. Reporting elements that cannot be incorporated into other existing Reports under this Contract will be reported in the Social Needs Service Coordination Report identified in Sub.Para. (3) below of this Para. s.

(3) Contractor shall submit to OHA, via Administrative Notice, a quarterly Social Needs Service Coordination Report no later than forty-five (45) days following the end of each calendar quarter. Contractor shall use the instructions and reporting template provided by OHA on the CCO Contract Forms Website. Each quarterly report must follow the instructions and specifications, meet all data field specifications, and include the minimum required data elements in order to be accepted by OHA. Contractor shall provide the following information in the quarterly report:

(a) HRSN Member Identification Requests,

(b) HRSN Closed Loop Referrals and Care Coordination – Manual, and

(c) HRSN Closed Loop Referrals and Care Coordination – CIE.

(4) Contractor shall submit to OHA, via Administrative Notice, a bi-annual report on Social Needs Providers no later than forty-five (45) days following the end of the first and third calendar quarters. A "Social Needs Provider" means a Provider offering services through Flexible Services, Supporting Health for All through Reinvestment (SHARE), HRSN, and other social needs spending programs as described in the Social Needs Service Coordination Report guidance document. Contractor shall submit this report using the

designated worksheet in the quarterly Social Needs Service Coordination Report template identified in Sub-Sub.Para. (3) above of this Para. s.

(5) Any and all updates OHA makes to the HRSN Guidance Document shall be considered effective thirty (30) days after the date OHA notifies Contractor, via Administrative Notice, of any such updates.

t. Prohibited Conduct. Without limiting any other applicable provisions of this Contract, Contractor shall not:

(1) Condition any Member's coverage or authorization of any benefit or service to which a Member is entitled on such Member's receipt of HRSN Services; or

(2) Use HRSN Services to reduce the availability of, discourage the use of, or jeopardize any Member's access to Covered Services; or

(3) Deny Medically Necessary Covered Services to any Member on the basis that the Member has requested, is currently receiving, or has previously received HRSN Services.

17. OHP Bridge - Basic Medicaid Program

a. In accordance with the approvals issued by CMS, the provision of services under the Oregon Health Plan Bridge - Basic Health Program (**"OHP Bridge - BHP"**) and the provision of services under the Oregon Health Plan Bridge - Basic Medicaid (**"OHP Bridge - Basic Medicaid"**) are required to be identical and the programs dependent on one another. For administrative purposes, the services provided to OHP Bridge - BHP members are subject to a separate agreement entered into by Contractor and OHA, whereas the services provided to OHP Bridge - Basic Medicaid members are the same as those available under this Contract except for the Health-Related Social Needs Services described in Secs. 15 and 16 of this Ex. B, Part 2.

b. With the exception of the foregoing excluded HRSN Services, all of the other terms and conditions of this Contract apply to the provision of the OHP Bridge - Basic Medicaid program and the Members covered thereunder are entitled to all of the other services and have the same rights as all other Members covered under Medicaid.

18. Reentry Health Care Services

a. Post-Release FCAA Services: Consistent with 42 USC §1396a(a)(84), Contractor shall provide Reentry FCAA Services for FCAA-Covered Youth in accordance with OAR 410-155-0010.[37] Contractor must document when it receives notification of the FCAA-Covered Youth's release from a Correctional Facility and when Reentry FCAA Services are provided. Reentry FCAA Services consist of:

(1) *Screening and Diagnostic Services.* FCAA-Covered Youth must be provided with all applicable EPSDT Covered Services described below of this Sub.Para. (1) within one (1) week, or as soon as practicable, after release from a Correctional Facility.

(a) Screening services, in accordance with the requirements in Section 1905(r)(1)-(4) of the Social Security Act (42 USC § 1396d(r)(1) (-4),)), must include, at a minimum: comprehensive health and developmental history (including assessment of both physical and mental health development), comprehensive unclothed physical examinations, appropriate vision and hearing testing, appropriate laboratory tests, and dental screening services.

[37] This new OAR will be effective 1/1/2026.

(b) Diagnostic services, in accordance with Section 1905(r)(5) of the Social Security Act (42 USC§1396d(r)(5~~),~~)), must include diagnosis of defects ~~in~~discovered during by the screening services provided under Sub-Sub.Para. (a) above of this Sub.Para. (1) which include, without limitation, those relating to vision and hearing, dental care, ~~and~~as well as providing, based on the outcome of the screening services, appropriate immunizations.

(c) Contractor shall ensure that Providers who provide the screening and diagnostic services described in this Sub.Para. (1) maintain documentation of such service provision in accordance with OARs 410-120-1260, and any other program specific rules in OAR Chapters 410 and 309.

(d) Contractor must, within the timeline described in Sub.Para. (1) above of this Para. A, conduct outreach to the FCAA-Covered Youth to facilitate the delivery of the services described in this Sub.Para. (1). Outreach efforts must comply with, at minimum, the following:

i. Making a minimum of two (2) additional attempts to contact the Member to facilitate completion of, or update, the Reentry Care Plan;

ii. Attempting to reach a Member utilizing two (2) mixed modalities (e.g., paper, digital or verbal) on different days and at different times; and

iii. Communicating in the ~~Member's~~Member's preferred method of communication and language. Auxiliary aids and services and alternate formats must be made available upon request.

(2) *Targeted Case Management:* Upon receipt of notification that an FCAA-Covered Youth's release from a Correctional Facility, Contractor must assign a Post-Release Case Manager to the Youth to deliver reentry targeted case management services as described in OAR 410-155-0010.[38] The means of notification under this Sub.Para. (2) shall be identified in the Reentry FCAA Services Guidance Document referenced in Para. b below of this Sec. 18. Reentry targeted case management services must be provided within the thirty (30) days following the FCAA-Covered Youth's release from a Correctional Facility. Contractor shall ensure the assigned Post-Release Case Manager meets the ~~requirements~~qualifications set forth in OAR 410-138-0060. In accordance with ~~OAR410~~OAR 410-155-0010, the Post-Release Case Manager shall:

(a) Complete a Reentry Health Risk Assessment (Reentry HRA) and Reentry Care Plan (RCP) with the FCAA-Covered Youth within thirty (30) days of their release from a Correctional Facility. ~~Results~~The Reentry HRA must developed with and agreed upon by the FCAA-Covered Youth or the FCAA-Covered Youth's guardian (or both, as applicable), and the results of the Reentry HRA must be documented in the FCAA-Covered Youth's Care Profile.

(3) The Post-Release Case Manager is responsible for all Reentry HRA documentation, including documentation of at least one face-to-face or Telehealth encounter/assessment with the FCAA-Covered Youth. This encounter must include direct screening or assessment (or both) as described in OAR 410-155-0010 and document such attempts as specified in OAR 410-155-0010.

[38] This new OAR will be effective 1/1/2026.

~~(b)~~(a) Contractor may utilize its existing HRA and Care Plan processes and resources to meet the requirements under this Sec. 18 if those existing processes and resources do in fact meet the Reentry HRA and RCP requirements established in OAR 410-155-0010.

~~(c)~~(b) Coordinate referrals and related activities (such as scheduling appointments for the Member) to help the FCAA-Covered Youth obtain needed services specified in the RCP.

~~(d)~~(c) Coordinate with the FCAA-Covered Youth to receive follow-up services as outlined in the RCP within thirty (30) days of their release from a Correctional Facility. The Post-Release Case Manager must ensure services address the needs outlined in the RCP, and as necessary, reflect any changes in the FCAA-Covered Youth's needs or health status following the initial completion of the RCP.

~~(e)~~(d) Follow up with the FCAA-Covered Youth to complete the Reentry HRA and RCP within thirty (30) days of their release from a Correctional Facility. Follow-up efforts must, at a minimum, comply with the following:

i. Making a minimum of two (2) additional attempts to contact the FCAA-Covered Youth to facilitate completion or updates of the Reentry Care Plan; and

ii. Attempting to reach the FCAA-Covered Youth utilizing two (2) mixed modalities (e.g., paper, digital or verbal) on different days and at different times; and

iii. Communicating in the FCAA-Covered Youth's preferred method of communication and language. Auxiliary aids and services and alternate formats must be made available upon request.

~~(f)~~(e) Coordinate adequate timely access to EPSDT Medically Necessary and Appropriate (as defined in 410-151-0001) Covered Services and any other Covered Services that may not be subject to a different or no Medically Necessary and Appropriate standard, as required by this Contract.

~~(g)~~(f) If an FCAA-Covered Youth received pre-release targeted case management services and was assigned a Pre-Release Case Manager, Contractor must ensure a Reentry Warm Handoff with the Pre-Release Case Manager (e.g., assigned Correctional Facility case manager) as well as the Member is conducted within thirty (30) days after the FCAA Covered Member is released from a Correctional Facility. To complete a Reentry Warm Handoff with the Pre-Release Case Manager, the Post-Release Case Manager must:

i. Request relevant health information from Correctional Facility and ensure transmission and receipt of such information complies with the requirements of this Contract and all Applicable Laws, including without limitation, HIPAA; and

ii. Conduct the Reentry Warm Handoff meeting, either in-person or via Telehealth, with the Member and the Pre-Release Case Manager.

~~(h)~~(g) Ensure FCAA-Covered Youth receive targeted case management services regardless of their participation in or completion of the Reentry HRA or RCP.

~~(i)~~(h) Document, and maintain such documentation, that FCAA-Covered Youth have been provided with reentry targeted case management services.

b. **Guidance Document:** OHA will produce a Reentry FCAA Services Guidance Document that summarizes the associated federal requirements and provides program guidance and high-level operational information. OHA shall post the FCAA Services Guidance Document on the CCO Contract Forms Website no later than ninety (90) days before the contract requirement goes into effect. The FCAA Services Guidance Document and will be updated from time to time as may be necessary, as determined by OHA in its reasonable discretion.

c. **Readiness Plan:** Contractor shall complete a reentry readiness plan prior to January 1, 2027, detailing how it will meet forthcoming OHA requirements for pre-release reentry health care services (e.g., pre-release care coordination). Contractor shall use the reentry readiness plan template(s) to document Contractor's readiness to provide pre-release reentry health care services. OHA will provide additional information about the reentry readiness plan requirements on the CCO Contract Forms Website prior to the date on which Contractor is required to begin providing pre-release reentry health care services. OHA will provide contractor with a required date for submission of the reentry readiness plan, via Administrative Notice, at least ninety (90) days before the required date for submission. In the event the additional information is not posted at least ninety (90) days prior to the date on which Contractor's reentry readiness plan is required to be submitted to OHA, OHA will notify Contractor, via Administrative Notice, of a new due date for such reentry readiness plan that is at least ninety (90) days from the date of posting. OHA will review Contractor's reentry readiness plan and notify Contractor, via Administrative Notice, of either (i) its approval or (ii) its request for additional detail.

[Remainder of page intentionally left blank]

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 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; and

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

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: (i) their civil rights under Title VI of the Civil Rights Act, Section 1557 of the ACA, and ORS Chapter 659A; (ii) their right to report a complaint of discrimination by contacting Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights; and (iii) how to contact Contractor's Section 1557 Coordinator identified in Ex. E, Sec. 24.

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 (including, without limitation, the linguistic characteristics of a national group), religion, sex (including sex characteristics, pregnancy and related conditions, sexual orientation, gender identity, sex stereotypes, sex assigned at birth, or gender otherwise recorded), age, disability, or health status in accordance with all Applicable Laws including Title VI of the Civil Rights Act, Section 1557 of the ACA, ORS Chapter 659A, and OAR 943-005-0060.

d. Provide equal access for all genders 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 for all Covered Services including but not limited to dental, vision, Specialist, and NEMT services. This applies to all non-English languages and sign language, not just those that OHA identifies as prevalent. Such services include interpretive services using relay or indirect communication. 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 in the State as specified in 42 CFR § 438.10(d)(4) for all Covered Services including but not limited to dental, vision, Specialist, and NEMT services. 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. Contractor shall make its staff and Provider Network for all Covered Services including but not limited to dental, vision, Specialist, and NEMT services aware of the URL for OHA's health care interpreter registry (https://hciregistry.dhsoha.state.or.us).

(1) Contractor shall, in accordance with 45 CFR 92.11, provide a notice of availability of language assistance services and auxiliary aids and services that, at minimum, states that Contractor provides language assistance services and appropriate auxiliary aids free of charge to its Members, the Member's Authorized Representatives, and any other individuals who are similarly responsible for the Member or the Member's care.

(a) The notice required above must be provided in no less than the fifteen (15) languages most commonly spoken by individuals residing in the state as well as in alternate formats for those Members with disabilities.

(b) The notice required under Sub.Para. (1) above must be provided by Contractor when providing services under this Contract as follows:

i. On an annual basis to Members;

ii. Upon request;

iii. In a conspicuous location on Contractor's website;

iv. In clear and prominent physical locations, in no smaller than 20-point sans serif font, where it is reasonable to expect individuals seeking service from Contractor to be able to read or hear the notice; and

v. In Contractor's electronic and written communications relating to all of the following:

A. Notices of nondiscrimination,

B. Notices of privacy practices,

C. Intake forms,

D. Notices of denial or termination of benefits or services, including Explanations of Benefits, and notices of appeal and grievance rights,

E. Individual's rights or benefits (or both),

F. Services that require or request a response from a Member or Potential Member (or both),

G. A public health emergency,

H. Consent forms and instructions related to medical procedures, operations, medical power of attorney, or living will (with an option of providing only one notice for all documents bundled together) (or all or any two of them),

I. Discharge papers,

J. Complaint forms, and

K. Member Handbooks.

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 CCO, any limitation Contractor imposes on Member's freedom 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 Ex. 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 ACA.

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, 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 Dual Special Needs 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. If available and appropriate, and only upon request by or with the consent of the Member, utilize electronic methods to communicate directly with a Member provided that such communications are in compliance with any and all Applicable Laws, including but not limited to HIPAA.

r. Contractor may use electronic communications without the Member's consent for purposes set forth in 42 CFR § 438.10, which includes Contractor's Member Handbook, Provider directory, and Preferred Drug List, but only if:

(1) The recipient has not requested that their correspondence be in written, hard copy format;

(2) The identical information is available in written, hard copy format and is provided to Members within five (5) Business Days of their 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, Member protection process, or Member specific communications;

(4) Language and alternative format accommodations are available;

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

(6) The information is placed in a prominent location on Contractor's public website and is in Readily Accessible digital format; and

(7) The electronic communication includes an easy means to opt out of future electronic messages and specify another means of delivery at any time.

s. Contractor shall ensure that all Contractor's staff who have contact with Potential Members are fully informed of Contractor policies, including: Enrollment; Disenrollment; Fraud, Waste and Abuse; Grievance and Appeal; Advance Directives; 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 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 Service 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, and

(8) Other educational materials as outlined in sub-regulatory guidance.

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 Dual Special Needs 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.

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 evaluation guidance and model language located on OHA's Quality Assurance Material Submission and Review webpage (www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx).

(2) Be in English and translated into all other Prevalent Non-English Languages that align with Contractor's particular Service Area;

(3) Include language in large print (18-point font) clarifying or otherwise advising Members:

(a) Auxiliary aids, sign language, and other interpretation services are available to deaf or blind Members, Members who are both deaf and blind, or Members with other disabilities that require any such service(s) pursuant to Section 1557 of the ACA or the Americans with Disabilities Act (ADA);

(b) Information shall be made available, at no cost to the Member, 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); and

(c) How to request and access these alternative formats.

(4) 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;

(5) 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

(6) Contractor may make its required Member information available on its website. If Contractor chooses to make such information available on its website, it must be: (i) placed in a prominent location and in Readily Accessible digital format; (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.

e. Contractor shall submit its Health Risk Assessment (HRA) to OHA, via Administrative Notice, for review and approval as follows: (i) by October 1 of each Contract Year for the upcoming Contract Year; (ii) upon any material change; and (iii) as requested by OHA within five (5) Business Days of any such request, as made by OHA from time to time.

(1) Changes to the HRA must not be implemented until approved in writing by OHA. If no changes have been made to the HRA since last approved by OHA, Contractor may, for its annual submission, submit to OHA, via Administrative Notice, an Attestation stating that no changes have been made the then-current HRA.

(2) OHA will notify Contractor within thirty (30) days from the due date, or within thirty (30) days from the received date if received after the due date, of the approval status of the HRA. 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 HRA, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

f. Contractor shall submit its (i) annual reminder for existing Members about the availability of the Member Handbook and Provider directory as required by OAR 410-141-3585 and (ii) materials for new Members listed in OAR 410-141-3585 that collectively comprise its Welcome Packet, except for the Member Handbook covered in Sec. 5 below, ("Annual Member Materials") to OHA, via Administrative Notice, for review and approval as follows: (x) all items, by October 1 of each Contract Year for the upcoming Contract Year; (y) only the affected item(s), upon any

material change; and (z) items requested by OHA within five (5) Business Days of any such request, as made by OHA from time to time.

(1) Changes to any of the Annual Member Materials must not be implemented until approved in writing by OHA. If no changes have been made to any of the items in the Annual Member Materials since last approved by OHA, Contractor may, for its annual submission, submit to OHA, via Administrative Notice, an Attestation stating that no changes have been made the then-current Annual Member Materials.

(2) OHA will notify Contractor within thirty (30) days from the due date, or within thirty (30) days from the received date if received after the due date, of the approval status of the Annual Member Materials. OHA will notify Contractor within the same period if additional time is needed for review. In the event that OHA does not approve one or more of the items in Contractor's Annual Member Materials, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

g. Contractor shall submit Member notices, informational, educational materials, and Marketing Materials to OHA, via Administrative Notice, for review and approval: (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 will provide written notice, via Administrative Notice to Contractor's Contract Administrator, of approval or disapproval of such submitted materials within the following timeframes, based on the date of OHA receipt of such materials: (i) forty-five (45) days for materials requiring non-expedited review; (ii) fifteen (15) days for materials for which Contractor requests, and OHA agrees to, expedited review; or (iii) four (4) days, where Contractor notifies OHA of an unanticipated emergency situation including but not limited to a natural disaster, public health emergency, immediate clinic/facility closure, or immediate Provider termination. 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 OHA's Quality Assurance Material Submission and Review webpage for guidance as to which materials do and do not require approval from OHA. The foregoing webpage is located at the following URL: www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx.

h. 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.

i. Contractor shall provide all material changes, as defined in the Guidance Document relating to Member materials, made to any and all materials previously reviewed and approved by OHA under this Sec. 4, Ex. B, Part 3, and any other provision of this Contract, to OHA, for review and approval. All material changes to the Member materials shall be delivered to OHA via

Administrative Notice. Review and approval or disapproval shall be made in accordance with Para. f of this Sec. 4, Ex. B, Part 3.

j. 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 and as specified in OAR 410-141-3585. Notice of any such material changes shall be provided at least thirty (30) days prior to the intended effective date of those changes, or no later than fifteen (15) days after receipt or issuance of the termination notice 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.

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 must contain all of the required language specified in the model Member Handbook and in the Member Handbook Evaluation Criteria, both of which are located on the CCO Contract Forms Website.

(1) The information included in the Member Handbook must be consistent with 42 CFR § 438.10(g), OAR 410-141-3580, OAR 410-141-3585, 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 translation services and auxiliary aids and services, and also advise them that such services are provided without charge to Members. This information must be in large type (18-point font) and located at the beginning of the Member Handbook.

b. Contractor shall provide its Member Handbook to OHA, via Administrative Notice, for review and approval: (i) Annually, not earlier than September 1 and not later than October 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. OHA will notify Contractor within thirty (30) days from submission of the approval status of its Member Handbook; OHA will notify Contractor within the same period if additional time is needed for review.

(1) Contractor's use of the model Member Handbook and its compliance with the Member Handbook Evaluation Criteria does not replace Contractor's obligation to fulfill all the requirements of OAR 410-141-3580 and OAR 410-141-3585 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 Secs. 4 and 5 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~~ deliver its OHA approved Member Handbooks ~~available~~ to Members ~~within: (i) fourteen (14) days of receiving OHA's initial 834 monthly~~

~~Enrollment transaction file 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 the means of delivery set out in Sec. 2, Para. ~~q~~r above of this Ex. B, Part 3 ~~of the Contract.~~

c. and OAR 410-141-3585. In addition, Contractor shall ~~notify~~:

~~**(2)**~~**(1)** Comply OAR 410-141-3585 with respect to (i) the timelines for notifying all newly enrolled Members of the availability of the then-current, OHA approved Member Handbook; (ii) the timelines for notifying all existing Members of each OHA approved revised Member Handbook; and ~~its location~~(iii) advising Members where on Contractor's website~~. Existing Members are those Members to whom Contractor has not mailed its Member Handbook due to Enrollment or re-Enrollment~~ the Member Handbook is located and how it can be accessed, as described in OAR 410-141-3585. ~~Contractor shall, at the time of such notification, offer to send its existing Members a printed copy of the applicable revised Member Handbook and promptly do so within five (5) days 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 42 CFR § 438.10(h), Contractor shall develop a Provider directory for its Members which encompasses the services delivered under this Contract. The Provider directory must be a single, comprehensive, and searchable resource that encompasses Contractor's entire Provider Network, including any Providers contracted by Subcontractors that serve Contractor's Members. Contractor may not utilize a Subcontractor's separate or standalone Provider directory to meet the Provider directory requirement. The Provider directory shall include 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 their Provider to the extent possible and appropriate within Contractor's Provider Network, 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 employed by Contractor or providing services under a Network Provider agreement with Contractor (or a Subcontractor or Downstream Entity), must have agreed to provide the Covered Services or items to its Medicaid and Fully Dual Eligible Members.

e. Contractor's Provider directory shall 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 include all of the information specified in OAR 410-141-3585.

g. Contractor's Provider directory must provide Members with the information necessary for accessing health care interpreters. Such information must, without limitation:

(1) Advise Members that, in accordance with OAR Chapter 950, Division 50,[39] Certified or Qualified Health Care Interpreters are required to be provided to Members who are in need of spoken language interpretation services;

(2) Advise Members that Certified or Qualified Health Care Interpreters who are licensed by the State of Oregon's Health Licensing Office in accordance with ORS 676.750 through 676.789 and 676.992 as well as OAR Chapter 816, must be provided to Members who are in need of sign language interpretation services;

(3) Identify the URL for OHA's health care interpreter registry, which is as follows: https://hciregistry.dhsoha.state.or.us/; and

(4) Expressly state that Members are neither expected nor required to schedule interpreters themselves and direct Members to Contractor's Member Handbook for information about how Members can ensure Providers arrange for interpreter services.

h. 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.

[39] This existing OAR will be updated effective 11/1/2025.

i. 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 submit such policies, procedures, criteria, and processes to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

j. 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.

k. Contractor shall make its Provider directory available on its website in both a searchable electronic format and 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 Ex. D of this Contract.

7. Grievance and Appeal System

Contractor shall create and implement a written Grievance and Appeal System as set forth with specificity in Ex. 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 Handbook and Provider manual.

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.

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 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 and the Member has not received services from another CCO, 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 reconciliation as described in Sec. 11 below of this Ex. B, Part 3.

h. Contractor shall actively support Full Benefit Dual Eligible (FBDE) Member enrollment decisions by providing information about opportunities to align and coordinate Medicaid benefits with Contractor's Affiliated or Contracted Medicare Advantage or Dual Special Needs Plan. This includes ensuring newly Medicare eligible members receive information about the affiliated Medicare Advantage or Dual Special Needs Plan at least sixty (60) days prior to the Medicare effective date.

i. Contractor shall actively support enrollment transition of Members to ensure the highest level of coverage for physical health, Behavioral Health, and Oral Health services, as relevant.

9. Disenrollment

The requirements and limitations governing Disenrollments contained in 42 CFR § 438.56 and OAR 410-141-3810[40] 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.

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/odhs/financial-recovery/Pages/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 reasons that are with and without cause.

(2) Subject to Para. d. below, OHA may Disenroll a Member upon request by Contractor consistent with OAR 410-141-3810 for reasons including, but not limited to:

(a) Member-specific situations;

(b) Uncooperative or disruptive behavior; or

(c) Fraudulent or illegal acts.

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

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

[40] This existing OAR will be updated effective 1/1/2026.

(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 ODHS 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. 13, of Ex. 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 Secure File Transfer Protocol with Contractor's current Member information in its Health Information System (HIS) for the same period. OHA has provided a guidance document on the CCO Contract Forms Website to assist Contractor with the Enrollment reconciliation and discrepancy reporting process.

b. Contractor shall provide a report of Contractor's current Member information to OHA using the Enrollment Reconciliation Certification Form available on the CCO Contract Forms Website. Contractor shall submit the Certification Form to OHA's Enrollment Reconciliation Coordinator via secure email to the email address indicated in Exhibit D-Attachment 1. Contractor's Certification Form must be submitted within fourteen (14) days of Contractor's receipt of the OHA 834 monthly enrollment transaction file. The Certification Form must be signed, dated, and completed as follows:

(1) If there are no discrepancies between the monthly Enrollment transaction file and Contractor's current Member information as reported in Contractor's HIS, Contractor shall indicate as instructed on the Certification Form that no discrepancies were found; or

(2) If there are discrepancies between the monthly Enrollment transaction file and Contractor's current Member information as reported in Contractor's HIS, Contractor shall indicate as instructed on the Certification Form that Enrollment discrepancies were found. When Contractor indicates that discrepancies were found, Contractor must also complete the template designated for identifying Enrollment discrepancies at the Member level and submit it with the Certification Form. The Enrollment discrepancies template is available to be downloaded from the CCO Contract Forms Website.

c. OHA will promptly acknowledge receipt of each submission by Contractor under Sub.Para. (1) or (2) of Para. b above. For Enrollment discrepancies submitted pursuant to Sub.Para. (2), OHA will review and verify each reported discrepancy and respond to Contractor with its findings prior to transmission of the next monthly Enrollment transaction file. OHA will correct all verified Member level discrepancies identified in Contractor's submission within sixty (60) days of receipt.

12. Identification Cards

a. Contractor shall provide an identification card to Members ("Member ID Card") 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 Member ID Cards confer no rights to services or other benefits under the OHP and are solely for the convenience of the Members and Providers. Information on all Member ID Cards shall meet the requirements set forth in the evaluation guidance located on OHA's Quality Assurance Material Submission and Review webpage (www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx).

(1) In keeping with 42 CFR 438.3 § (s)(7), Contractor must (i) assign and exclusively use a unique Bank Identification Number (BIN) and Processor Control Number (PCN) combination and group number identifier and (ii) include its BIN, PCN, and group number identifier on each Member ID Card. If Contractor has a Medicaid managed care contract with a state other than Oregon, Contractor's BIN, PCN, and group number identifier for Members covered under this Contract may be the same as those for Medicaid enrollees covered under Contractor's contract with the other state.

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 ODHS and OHA offices within Contractor's Service Area.

e. Contractor shall provide all proposed Marketing Materials to OHA for review and approval prior to use and distribution. The Marketing Materials shall be provided to OHA via Administrative Notice. 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, Ex. 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 CCO-provided benefits with Medicare Advantage or Dual Special Needs Plans, as described in OAR 410-141-3575 and OAR 410-141-3580.

[Remainder of page intentionally left blank]

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 assessments. 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 a Health Risk Assessment (**"HRA"**) of each new Member's needs in accordance with OAR 410-141-3865. Contractor must include in its Care Coordination policies and procedures, a policy and procedure (**"P&P"**) for the administration of all HRAs. For the purpose of evidencing compliance, the HRA P&P must require that each HRA performed for a new Member is documented to include, without limitation, the following: (i) the HRA was completed, (ii) the results of each HRA, and (iii) the manner in which the relevant information was used to inform the Member's risk stratification and Care Coordination activities and supports. If the HRA requires additional information from the Member, Contractor shall similarly document all attempts to reach the Member by telephone and mail, including subsequent attempts. Contractor shall ensure all personnel responsible for conducting HRAs comply with the foregoing requirements and that all documentation is maintained in the Member's file.

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 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 Dual Special Needs Plans and Medicare Providers for FBDE Members;

(c) ODHS Area Agency on Aging/Aging and People with Disabilities Offices or Office of Developmental Disability Services offices or case managers and any developmental disability or LTSS service Providers (or both) as outlined in OARs 410-141-3860, 410-141-3865, and 410-141-3870 and the CCO-LTSS MOU Guidance Document posted on the CCO Contract Forms Website.

(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 in accordance with OAR 410-141-3860;

(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, including Wraparound for children with Behavioral Health disorders.

c. 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. Contractor shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week, when Medically Appropriate as set forth in OAR 410-141-3515. In the case of HRSN Services, Contractor shall make such Services available in accordance with OAR 410-120-2020 .

(1) For Members requiring Medication Assisted Treatment (MAT), Contractor shall:

(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. (1)(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.

(2) 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

(3) 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,

(f) FBDE Members enrolled in Contractor's Affiliated MA or Dual Special Needs Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes, and

(g) Discharged from carceral settings (i.e., state or federal prisons, local correctional facilities, juvenile detention facilities – including FCAA-Covered Youth – and Tribal correctional facilities) back to the community or another residential or care setting.

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 individuals 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) In accordance with OAR 410-141-3865 and 410-141-3870, develop and implement a written Care Plan, and any and all revisions and updates thereto, for each such Member which must be: (i) developed by the entity designated as primarily responsible for coordinating such Member's services, with Member participation and in consultation with any Providers, Specialists, guardians, and other relevant individuals identified in 410-141-3865; (ii) approved by Contractor in a timely manner; and (iii) revised upon Assessment of function, need, or at the request of the Member. All Care Plans must be developed in accordance with any and all 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 the entity designated as primarily responsible for coordinating such Member's services, 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 CCOs 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 III of the Americans with Disabilities Act, Title VI of the Civil Rights Act, and Section 1557 of the ACA by assuring communication and delivery of Covered Services to Members with diverse cultural and ethnic backgrounds. Contractor shall, in order to ensure the communication about, and delivery of, Covered Services in compliance with such Acts, provide, without limitation:

(1) Certified or Qualified Health Care Interpreter services for those Members who have difficulty communicating due to a medical condition, a disability, or have limited English proficiency; or

(2) Auxiliary aids and services when no adult is available to communicate in English or Certified or Qualified Health Care Interpreters cannot be made available by telephone.

i. Contractor shall maintain written policies, procedures, and plans relating to the communication about, and delivery of Covered Services in compliance with Para. h above of this Sec. 2 in accordance with the requirements of OAR 410-141-3515.

j. Contractor shall comply with the requirement of Title III 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.

k. 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 Ex. I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.

l. Contractor shall develop and implement civil rights policies and procedures that comply with 45 CFR §92.8. Contractor shall provide its relevant employees and Subcontractors with training on its civil rights policies and procedures required by 45 CFR § 92.8 as is necessary for the employees and Subcontractors to carry out their job responsibilities and functions. The foregoing training must be in compliance with 45 CFR §92.9 and this Sec. 2 and any other applicable provisions of this Contract.

m. 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 OARs 410-141-3515, 410-141-3860, 410-141-3865, and 410-141-3870.

n. 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 OARs 410-141-3860, 410-141-3865, and 410-141-3870 and as required by 42 CFR 438.208 (b)(1) and (2).

(1) In accordance with ORS 414.773(4), Contractor must allow a Member to choose a new PCP at any time.

o. 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.

p. 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.

q. 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.

r. 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 employ and promote:

(1) An integrated approach to ensuring FBDE Members have a PCPCH or PCP,

(2) Integrated care plan development,

(3) Coordination of Care Setting Transitions to reduce readmissions,

(4) Collaboration to ensure and Monitor Member access to preventive screenings and tests and Behavioral Health services,

(5) Care Coordination with affiliated Medicare plans and Medicare Providers as outlined in OARs 410-141-3860, 410-141-3865, and 410-141-3870;

(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 Dual Special Needs Plan enrollment and communication mechanisms for newly eligible Medicare Members.

s. 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.

t. Contractor shall ensure that a Provider:

(1) Complies with the requirements of Enrolled Oregon House Bill 2359 (2021) regarding OHA's health care interpreter registry, language proficiency requirements for bilingual Providers, and documentation of all interpreter services including good faith efforts to work with OHA Qualified or Certified Health Care Interpreters before working with an interpreter who is not listed on OHA's interpreter registry;

(2) Works with a Certified Health Care Interpreter or a Qualified Health Care Interpreter when interacting with Member, or a caregiver of a Member, who has limited English proficiency or who communicates in signed language; and

(3) Is reimbursed for the cost of the interpreter.

u. Contractor shall, as required by and in accordance with the applicable deadlines set forth in OAR 410-141-3515,[41] submit (i) the annual interpreter services self-assessment and (ii) the language access and interpreter services reports to OHA via Administrative Notice.

(1) Contractor shall use the language access and interpreter services reporting template provided by OHA on the CCO Contract Forms Website.

(2) Contractor shall complete and submit the interpreter services self-assessment by entering the information into a web-based portal. OHA will provide Contractor, via Administrative Notice, with information about how to access the portal. OHA will provide Contractor with a reference copy of the self-assessment so that Contractor may review the requested information prior to entering it into the portal. Such reference copy will be posted on the CCO Contract Forms Website.

v. Contractor shall ensure that any phone numbers that Members and Potential Members are directed to use to contact Contractor are answered by a phone system that meets the following requirements:

(1) The message played when the phone system answers a call must, at a minimum, be in English and Spanish. Contractor may elect to include one or more other languages. The system instructions in each language must clearly and accurately explain to the caller how to navigate the system. The instructions in each language must clearly explain what

[41] OHA expects to update OAR 410-141-3515 during 2026 to adjust the submission frequency for the language access and interpreter services report.

the caller should do if they speak a language other than English, including how to request an interpreter.

(a) Contractor may choose to establish a dedicated queue within its phone system for non-English speaking callers. In such cases, the initial phone system message must clearly and accurately explain, at a minimum, in English and Spanish and, as applicable, any other language(s) elected by Contractor, how to access this queue. Once connected to the dedicated queue, the instructions must be in Spanish and, as applicable, the other language(s), and clearly and accurately explain to the caller how to navigate the system.

(2) If the phone system does not provide the opportunity for the caller to identify their non-English language prior to connecting the call to a live representative, then, prior to connecting the call, the system instructions must advise the caller of this fact and further advise them to state their need for an interpreter and identify their non-English language when the call is answered.

(3) If the phone system provides the opportunity for the caller to identify their non-English language prior to connecting the call to a live representative, then the call must be answered by either (i) a representative who speaks the caller's non-English language or (ii) a representative who already has an interpreter on the call who speaks the caller's non-English language.

w. Contractor shall provide Members with access to Birth Doulas, Lactation Counselors, and Lactation Educators, pursuant to ORS 414.668 and in accordance with OAR 410-130-0015.[42] Contractor shall provide Members with information about how to access services from Birth Doulas, Lactation Counselors, and Lactation Educators on its website and in its Member Handbook.

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 Ex. D, Sec. 19 and Ex. B, Part 4, Sec. 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:

[42] This existing OAR will be updated effective 1/1/2026.

(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 individuals, IV drug users, and those with Medication Assisted Treatment needs.

(8) Contractor shall have a mechanism to Monitor and ensure that there is adequate Provider Network capacity based on the needs of Members and Potential Members, specific to Substance Use Disorder services at all levels of care in the ASAM Criteria, including prescribers for Medication Assisted Treatment and opioid treatment programs. The mechanism developed shall be based on the methodology established pursuant Ex. B, Part 4, Sec. 3, Para. a (2).

4. Provider Selection

Contractor shall establish written policies and procedures that comply with credentialing and re-credentialing requirements outlined in OAR 410-141-3510,[43] 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 Capacity Reports as set forth in Ex. 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) Give the affected Providers written notice of the reason for its decision not to include individuals or groups of Providers in its Provider Network, include with such notice Contractor's Provider selection policy, and provide an internal review process for the affected Providers;

(4) 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. This paragraph does not:

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

(b) Require that Contractor contract with any health care Provider willing to abide by the terms and conditions for participation established by Contractor;

(c) Preclude Contractor from establishing varying reimbursement rates based on quality or Performance Measures consistent with Contractor's responsibilities under this Contract; or

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

(5) 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;

(6) Ensure that all Traditional Health Workers, whether they are employed by Contractor or provide services under a Network Provider agreement with Contractor, undergo and meet the requirements for, and pass the background check required of for THWs, as described in OAR 950-060-0070;

[43] This existing OAR will be updated effective 1/1/2026.

(7) Ensure that all health care interpreters, whether for spoken or signed languages, are Qualified or Certified Health Care Interpreters in accordance with OAR Chapter 950, Division 50[44] and that sign language interpreters are licensed pursuant to ORS 676.750 through 676.789 and 676.992 and in accordance with OAR Chapter 816; and

(8) Terminate its Network Provider agreement with a Provider immediately upon receipt of Legal Notice from the State that a Provider is precluded from being enrolled as a Medicaid Provider.

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 until the Provider has been approved for Enrollment by OHA, as described in Ex. B, Part 4, Sec 5 b.

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 ACA Section 6402, 42 CFR § 438.214, 42 CFR § 455.400-455.470 (excluding § 455.460), OAR 410-141-3510 and Ex. 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. OHA has established categorical risk levels for Providers and Provider types listed on the OHA webpage for tools for OHP health plans (https://www.oregon.gov/oha/HSD/OHP/Pages/Plan-Tools.aspx). When credentialing Providers or Provider types designated by OHA as "moderate" or "high" risk, Contractor shall not execute any contract with such Providers unless the Provider has been approved for Enrollment by OHA. OHA is responsible for performing site visits for such "moderate" or "high" risk Providers and for ensuring that such "high" risk Providers have undergone fingerprint-based background checks. For a Provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, OHA deems this Provider to have satisfied the same background check requirement for OHA Provider Enrollment. OHA's Provider Enrollment files are updated weekly and provided on the aforementioned OHA webpage.

c. If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Contractor shall document, certify, and report in the DSN Provider Capacity 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:

[44] This existing OAR will be updated effective 11/1/2025.

(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 Capacity 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.

d. Contractor shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and must provide accurate and timely information about license or certification expiration and renewal dates in the DSN Provider Capacity 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.

e. 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.

f. 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.

g. 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.

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

i. 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. 12, Para. b, Sub. Para. (9) of Ex. B, Part 9.

j. Contractor shall provide written notice prior to the contract expiration date to any Participating Provider whose contract will not be renewed by Contractor.

k. Contractor shall provide Administrative Notice to OHA's Provider Enrollment Unit within fifteen (15) days of terminating any Participating Provider contract when such Participating Provider termination is a for-cause termination, with a statement of the cause including but not limited to the following:

(1) Failure to meet requirements under the Contract or Contractor's Subcontract with its Subcontractor;

(2) For reasons related to Fraud, integrity, or quality;

(3) Deficiencies identified through compliance Monitoring of the entity; or

(4) Any other for-cause termination.

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. 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.

c. Contractor shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of Health System Transformation.

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

e. 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; and

(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.

7. Indian Health Care Providers

a. With respect to Indian Health Care Providers (IHCPs), Contractor shall:

(1) Offer contracts to all Medicaid eligible IHCPs in its Service Area, offering reimbursement at the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the IHCP if billed to OHA for a FFS Member;

(2) Provide CCO-enrolled Indian Health Services beneficiaries who have been seen and referred by IHCPs with access to specialty and primary care within Contractor's Provider Network. The CCO-enrolled Indian Health Services beneficiaries must be provided with such access regardless of whether a referring IHCP is one of Contractor's Network Providers;

(3) 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

(4) 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 in writing 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.

8. Care Coordination

Contractor shall provide all of the elements of Care Coordination as set forth below in this Sec. 8, Ex. B, Part 4 and in accordance with OARs 410-141-3860, 410-141-3865, and 410-141-3870.

a. Contractor shall work with Affiliated Medicare Advantage and Dual Special Needs Plans serving FBDE Members to ensure that affiliation agreements detail and facilitate the priorities, partnerships, and processes outline therein to allow access to and coordination with any OHP providers and services, especially those outside Medicare network and including culturally specific community-based organizations, community-based Behavioral Health services, LTSS or developmental disability Providers and organizations, and mental health crisis management services. Contractor shall ensure Care Coordination services are provided in accordance with OARs 410-141-3860, 410-141-3865, and 410-141-3870.

b. Contractor shall coordinate with the applicable entities the development and maintenance of an Memorandum of Understanding (MOU) that incorporates processes including monitoring for care planning, care transitions, and communication, as outlined in the CCO-LTSS Guidance Documents provided by OHA on the CCO Contract Forms Website and https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-LTSS.aspx.

(1) 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 ODHS-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) Contractor shall document and submit to OHA annually, via Administrative Notice, no later than May 30, an MOU report on coordination activities and required domain metrics for the preceding Contract Year as outlined in the CCO-LTSS Guidance Document posted on the CCO Contract Forms Website. Contractor shall use the MOU report template provided by OHA on the CCO Contract Forms Website.

c. 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 ODHS 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 Care Setting 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. 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.

9. Care Integration

a. Contractor shall provide the elements of integrated care as set forth in this Para. a, Sec. 9, 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 Dual Special Needs 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 Care Plans to the extent feasible;

(3) Received comprehensive Care Setting Transition supports and services, 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 Assessment and, as appropriate, assessed for Long Term Services and Supports

10. Delivery System Dependencies

a. 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.

b. Cooperation with Dental Care Providers

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

c. 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.

11. Evidence-Based Clinical Practice Guidelines

Contractor shall adopt, disseminate, and apply practice guidelines as specified in 42 CFR § 438.236 (b), (c) and (d). 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.

12. Subcontract Requirements

Contractor's Subcontracts, including those entered into with Participating Providers that meet the definition of a Subcontractor or Downstream Entity, must comply with the requirements set forth in this Sec. 12 of Ex. B, Part 4 and OAR 410-141-3505,[45] which includes requirements specific to Dental Subcontractors pursuant to Section 3 of Enrolled Oregon House Bill 2211 (2025). However, nothing in this Sec. 12 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 and the applicable OARs. All requirements set forth in this Sec. 12 of Ex. B, Part 4 and any other applicable provisions of this Contract that apply to Subcontractors also apply to Downstream Entities except where expressly stated that the requirement(s) does not apply to Downstream Entities. 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

[45] This existing OAR will be updated effective 1/1/2026 for Enrolled Oregon House Bill 2211 (2025) relating to Dental Subcontractors.

(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 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. 12, 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. If Contractor has a contract with a prospective Subcontractor that involves performance of services on behalf of Contractor for a Medicare Advantage plan operated by Contractor or its parent company or subsidiary, Contractor may satisfy the requirements of this Sub.Para. (4) by submission of the results of its Subcontractor readiness review evaluation required by this Sub.Para. or Medicare, but only for Work identical to that to be Subcontracted under this Contract and only if the readiness review has been completed no more than three (3) years prior to the effective date of the prospective Subcontract.

(5) Contractor shall ensure that all Subcontractors are screened for exclusion from participation in federal programs, in compliance with 42 CFR 438.610. 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 this Contract. Work, activities, and other obligations that Contractor shall not Subcontract are identified throughout this Contract. Subject to the provisions of this Sec. 12, 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 by 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 by Contractor to a Subcontractor, Subcontracted by a Subcontractor to a Downstream Entity, or any combination thereof. In the Report, Contractor shall identify the Downstream Entity ultimately performing the Work or other activities required to be performed under this Contract, regardless of the tiers of Subcontracts that exist between Contractor and that Downstream Entity. The Subcontractor and Delegated Work Report must be provided to OHA by no later than March 1 of each Contract Year and within thirty (30) days after there has been any change in a Subcontractor or Downstream Entity or the Work Delegated to such Subcontractor or Downstream Entity. Contractor shall utilize the Subcontractor and Delegated Work Report Guidance Document and reporting template located on the CCO Contract Forms Website. The Subcontractor and Delegated Work Report shall include, but is not limited to, the following:

(a) The legal name of each direct or indirect Subcontractor;

(b) The scope of Work or activities (or both) being Subcontracted to each direct or indirect Subcontractor;

(c) The current risk level of each direct Subcontractor (High, Medium, Low) as determined by Contractor based on the level of Member impact of Subcontractor's Work, the results of any previous Subcontractor Performance Report(s), and any other factors deemed applicable by Contractor or OHA or any combination thereof, except that Contractor must apply the following OHA criteria to identify a High risk Subcontractor:

i. A Subcontractor is considered High risk if the Subcontractor:

A. Provides direct service to Members or whose Work directly impacts Member care or treatment; or

B. Has had one or more formal review findings within the last three (3) years for which OHA or Contractor or both has required the Subcontractor to undertake any corrective action; or

C. Both A and B above.

(d) Copies of ownership disclosure form, if applicable, for each direct Subcontractor;

(e) Any ownership stake between Contractor and each direct Subcontractor; and

(f) An attestation that Contractor has (i) conducted a readiness review of each direct Subcontractor, unless Contractor relied on the Subcontractor's readiness review required by Medicare as permitted by Sub.Para. (4) or Contractor previously conducted a readiness review for Subcontractor's Work performed under this Contract within the last three (3) years; (ii) confirmed that each direct Subcontractor was and is not excluded from participation in federal program; (iii) confirmed all direct Subcontractor employees are subject to, and have undergone, criminal background checks; (iv) that the written Subcontract entered into with the direct Subcontractor meets all of the requirements set forth in this Ex. B, Part 4 and other applicable provisions of this Contract; and (v) conducted a formal compliance and performance review of each direct Subcontractor consistent with Sub.Para. (13) below of this Ex. B, Part 4.

(9) In addition to the obligations identified as being precluded from Subcontracting under this Sec. 12, Ex. B, Part 4 of this Contract, and as may be set forth in any other provision of this Contract, the following 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 its Subcontractors' contracts with Providers prohibit Providers from billing 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 services being provided, in accordance with OAR 410-141-3565.

(12) In accordance with Ex. I of this Contract, Contractor shall provide every Subcontractor, at the time it enters into a Subcontract, its OHA-approved written procedures for its Grievance and Appeal System. Contractor shall ensure that its Subcontractors provide copies of the same written procedures to every Provider contracted by the Subcontractor.

(13) Contractor shall Monitor the performance of all Subcontractors on an ongoing basis and also perform timely formal reviews of their compliance with all Subcontracted obligations and other responsibilities, for the purpose of evaluating their performance, which must identify any deficiencies and areas for improvement. Such reviews shall be documented in a Subcontractor Performance Report (SPR). Contractor shall make a conclusion in each SPR 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. SPRs are timely when conducted in accordance with the following schedule:

(a) A High risk Subcontractor must be reviewed at least annually.

(b) A Low or Medium risk Subcontractor must be reviewed at least every three (3) years.

(14) The SPR must include, at a minimum, the following elements:

(a) Date of SPR completion;

(b) SPR look-back time period;

(c) List of Contractor's formal compliance reviews of Subcontractor or the specific deliverables used to monitor Subcontractor's performance (or any combination thereof) and the look-back time periods for the applicable reviews or deliverables;

(d) If Subcontractor failed to submit a deliverable, submitted a deliverable untimely, or submitted an incomplete deliverable (or all or any combination thereof) and such submission(s) affected Contractor's ability to adequately monitor Subcontractor's Work, identification of the deliverable involved and the follow-up action taken by Contractor or Subcontractor (or both);

(e) Overall outcome of the SPR and identification of the level of Subcontractor's performance (i.e., compliant, partially compliant, non-compliant);

(f) Any complaints or Grievances filed in relation to Subcontractor's Work;

(g) How often Subcontractor's employees are screened and Monitored for federal exclusion from participation in Medicaid;

(h) Result of Subcontractor's compliance program review (i.e., compliant, partially compliant, non-compliant) and whether Subcontractor monitors its Downstream Entity(ies), if applicable; and

(i) Any deficiencies identified by Contractor related to Work performed by (i) Subcontractor or (ii) its Downstream Entity(ies) or both.

i. The list of deficiencies shall include the findings/areas for improvement identified during the one- or three-year review period, as applicable, including details on what those are and how they were/will be remediated.

Contractor shall utilize the resources for its SPRs provided by OHA on the CCO Contract Forms Website. Such resources may include but are not limited to evaluation criteria and a Guidance Document.

(15) If Contractor has Subcontracted for services under a Medicare Advantage plan operated by Contractor or its parent company or subsidiary, Contractor may satisfy the requirements of Sub.Paras. (13) and (14) above of this Para. a, Sec. 12 by submitting the results of its Medicare required Subcontractor compliance review ("Medicare Compliance Review"), provided that (i) the Work performed by such Subcontractor was identical to the Work Subcontracted under this Contract, and (ii) the time period for the Medicare Compliance Review is identical to or includes the same time period for the SPR required to be submitted under this Contract.

(16) For each High risk Subcontractor, Contractor shall provide a copy of the SPR (or the substituted Medicare Compliance Review) to OHA, via Administrative Notice, within thirty (30) days of completion of the SPR and no later than December 31 of the Contract Year in which the Report was completed For each Low or Medium risk Subcontractor, Contractor shall provide a copy of the SPR (or the substituted Medicare Compliance Review) to OHA upon request, via Administrative Notice, within five (5) Business Days after request by OHA. Contractor shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has Delegated to a Subcontractor.

(17) In the event Contractor identifies, whether through ongoing Monitoring or formal annual compliance review, deficiencies or areas for improvement in a Subcontractor's performance, Contractor shall cause the Subcontractor to either initiate a Corrective Action Plan (CAP) or take other action (which must be documented) to remedy such deficiencies within thirty (30) days of Contractor's confirmation thereof. Contractor must, in substantial compliance with guidance, impose a CAP on any Subcontractor who materially breaches its Subcontract with Contractor. Contractor shall utilize the Subcontractor CAP evaluation criteria or Guidance Document (or both) provided by OHA on the CCO Contract Forms Website to ensure that the Subcontractor CAP meets OHA's requirements. Contractor shall provide to OHA, via Administrative Notice, a copy of each Subcontractor CAP documenting:

(a) Date of Contractor's notice to Subcontractor about the requirement to submit a CAP;

(b) How the deficiencies were identified (i.e., formal compliance review, ongoing monitoring, member complaint, etc.);

(c) Date the deficiencies were identified;

(d) Details of the deficiencies;

(e) Root cause of the deficiencies;

(f) Actions required of Subcontractor to remedy the deficiencies; and

(g) Expected completion date of the CAP.

The foregoing Administrative Notice shall be made to OHA within thirty (30) days after Contractor's notice to Subcontractor about the requirement to submit a CAP.

(18) Contractor shall provide OHA with an update on the status of the CAP at such time that the Subcontractor has (i) successfully completed the CAP or (ii) failed to fully remedy the underlying deficiency(ies) by the deadline identified in the CAP. Such update shall be provided to OHA, via Administrative Notice, within fourteen (14) days after the deadline for completion as 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) 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, require such 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 to require any contracted 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;

(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. 18, 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 and that Subcontractor provides Covered Services to Members, including but not limited to in the capacity of Participating Provider, Contractor shall provide written notice, translated as appropriate, of such termination to Members who receive Covered Services from the Subcontractor as follows: (i) at least thirty (30) days prior to the effective date of termination or (ii) within fifteen (15) days after receipt or issuance of the termination notice if the Subcontractor has not given Contractor sufficient notification to meet the thirty day (30) notice requirement.

(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 Subcontractor and Delegated Work Report.

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 of a written request from OHA, 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. Additionally, within five (5) Business Days after receipt of a written request from OHA, Contractor shall provide OHA with any and all copies of Subcontracts entered into by Contractor's Subcontractor(s) that relate to the services required to be provided under this Contract. OHA will make its requests for the applicable Subcontracts via Administrative Notice, and Contractor shall provide such Subcontracts to OHA in the manner directed by OHA in the applicable requests.

13. 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.oregon.gov/biz/programs/COBID/Pages/default.aspx, are provided an equal opportunity to compete for and participate in the performance of any Subcontracts under this Contract.

14. 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 who provide services under a Network Provider agreement with Contractor, Contractor shall provide to OHA, via Administrative Notice, a written plan for transferring the Members and an updated DSN Provider Capacity Report, as required under Ex. 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 Dual Special Needs 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 Dual Special Needs 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 Dual Special Needs Plan (or both) closure or reduction in Service Area, Contractor shall work with the local ODHS 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 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 CCO 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. 14, Ex. B, Part 4 of this Contract, Contractor retains responsibility for providing access to all Covered Services, without limitation, for each Member until the effective date of Disenrollment. Unless specified otherwise by OHA, Disenrollments shall be effective 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. 14, Ex. B, Part 4 of this Contract. OHA shall have the right, in its discretion, to withhold up to twenty percent (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 Sec. 14, 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 Ex. 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 Ex. C of this Contract:

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

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

[Remainder of page intentionally left blank]

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

[Remainder of page intentionally left blank]

Exhibit B – Statement of Work – Part 8 – 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 Sec. 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 promptly notify OHA, via Administrative Notice, 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 943-120-0100 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. 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 Sec. 2 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, Contractor and its Provider Network may disclose information about Members to OHA and ODHS for the purpose of administering the laws of Oregon.

f. Pursuant to OAR 943-014-0320, in the event Contractor Discovers an incident or has a reasonable belief there has been an incident involving its (i) Health Information System; (ii) any of its other computer systems; or (iii) 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 one (1) Business Day after Contractor makes such Discovery, provide Administrative Notice of such incident to the Privacy Compliance Officer in OHA's Information Security and Privacy Office (ISPO) at DHS.PrivacyHelp@odhsoha.oregon.gov, with a follow-up telephone call to ISPO's Privacy Reporting Line at 503-945-5780.

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 the ACA 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 contracted 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 IHCPs that are Non-Participating Providers 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. Additionally, Contractor and its Providers shall comply with OAR 410-120-1280 relating to when a Provider may bill a Medicaid recipient and when a Provider may send a Medicaid recipient to collections for unpaid medical bills.

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(5)(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.

j. Contractor shall not restrict billing by or reimbursement to a pharmacist or a pharmacy for the prescription, dispensation, and administration of preexposure and post-exposure prophylactic antiretroviral therapies pursuant to ORS 689.645 and 689.704, based solely on their provider type. Instead, Contractor shall reimburse a pharmacist or pharmacy, in the same manner as would be provided to any other Provider, for (i) the prescription, dispensation and administration of preexposure and post-exposure prophylactic antiretroviral therapies pursuant to ORS 689.645 and 689.704 and (ii) the service provided by the pharmacist, consistent with Section 1 of Enrolled Oregon House Bill 2942 (2025).

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 120 days of the Date of Service. However, Providers may, if necessary, submit their claims to Contractor within 365 days of 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, in whole or in part, of payment for a service rendered 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, in whole or in part, of payment for a service rendered; and

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

d. Contractor shall establish a timeframe in its written policies and procedures allowing Providers to make re-submissions or appeals for a minimum of one hundred eighty (180) days after the initial adjudication date under the following circumstances:

(1) The initial claim was timely submitted and needs correction;

(2) The initial claim has prompted a Provider appeal pursuant to OAR 410-120-1560; or

(3) Any other reason not included in Para. b above in this Ex. B, Pt. 8, Sec. 5 that would otherwise require a re-submission of the claim.

e. 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.

f. 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.

g. Contractor shall pay Indian Health Care Providers for Covered Services provided to those Members who are eligible to receive services from such Providers. Payment to IHCP for Covered Services shall be made as follows:

(1) With respect to all Members, Participating IHCPs are paid at either: (a) the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the IHCP if billed to OHA for a FFS Member; or (b) upon mutual agreement of the parties, 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) With respect to Covered Services for AI/AN Members and to Family Planning Services and HIV/AIDS prevention services for all Members, Non-Participating IHCPs that are not a FQHC must be paid at the greater of: (a) the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the IHCP if billed to OHA for a FFS Member; or (b) 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) With respect to Covered Services for AI/AN Members and to Family Planning Services and HIV/AIDS prevention services for all Members, Non-Participating IHCPs that are a FQHC must be paid at the greater of: (a) the same IHS or PPS encounter rate, as applicable to the specific IHCP, that OHA would pay the IHCP if billed to OHA for a

FFS Member; or (b) 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.

h. The Parties acknowledge that the IHCP IHS and PPS encounter rates for each calendar year are established by the federal government and announced to the public on a schedule that may not align with the calendar year cycle. Upon the federal government's publication of the calendar year's new rates, Contractor shall promptly (i) update its systems with the new rates and (ii) pay all eligible IHCP claims at the applicable new rate. The obligation to pay all eligible claims at the new rates includes reprocessing previously paid claims in order to make the IHCP whole at the new rate for the calendar year. Contractor shall undertake such retroactive activity and make any required, subsequent payments that may arise as a result of any encounter rate changes without regard to the IHCP's Network Provider status and without requiring any IHCP to initiate claims reprocessing or payment at the applicable new rate. Contractor shall timely pay IHCPs at the then-current rates and must not delay or otherwise hold-back payment to IHCPs in anticipation of the federal government's publication of the new rates for the calendar year. In accordance therewith, Contractor shall not condition payment of the IHCP rate for the new calendar year on the execution of any contract amendment by its Participating IHCPs, unless the IHCP indicates that it no longer wishes to contract at the encounter rate.

i. Contractor shall make prompt payment to IHCPs including Indian Tribes, Tribal Organizations, or Urban Indian Organizations, in the same time frame required under Para. e above of this Sec. 5, Ex. B, Part 8.

j. 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.

k. Contractor shall pay for Emergency Services that are performed by Non-Participating Providers as specified in OAR 410-141-3840.

l. 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.

m. Contractor shall comply with the requirements related to claims payment for behavioral health and physical health services provided on the same day or in the same facility specified in Section 10 of Enrolled Oregon Senate Bill 1529 (2022) as specified in OAR Chapter 410.

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 Dual Special Needs 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/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance06132022.pdf.

(1) In the event CMS audits Contractor's Affiliated MA Plan or its Affiliated Dual Special Needs 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 Dual Special Needs 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 OARs 410-141-3860, 410-141-3865, and 410-141-3870, 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-benefits-recovery/coba-trading-partners/agreement; 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 Dual Special Needs Plans. If there has been any change in Contractor's Affiliated MA and Dual Special Needs Plans since the prior Contract Year, Contractor shall submit to OHA, via Administrative Notice, by February 15 of the current Contract Year an Attestation stating that the automated crossover claims process is fully implemented and in effect.

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 Dual Special Needs 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 State's All Payer All Claims (APAC) Reporting Program established by OHA in accordance with its authority under ORS Chapter 442 and as implemented by OAR Chapter 409, Division 25. Contractor is subject to all of the obligations arising under the program as set forth in the aforementioned Applicable Laws. Information about the APAC Program, including reporting requirements, due dates, compliance, and enforcement, is found at: https://www.oregon.gov/oha/hpa/analytics/Pages/All-Payer-All-Claims.aspx. The APAC Program requirements as detailed in the foregoing website are incorporated by reference as though fully set forth in this Sec. 8.

9. Cost Growth Target Program

Contractor shall participate in the Cost Growth Target Program established by OHA in accordance with ORS 442.385 and 442.386 and as implemented by OAR Chapter 409, Division 65. Contractor shall submit any reports required by the Cost Growth Target Program as applicable to Contractor as a mandatory reporter for the Program. Information about the Cost Growth Target Program, including the method, format, and data required for reports and applicable due dates is found at: https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-data.aspx.

10. Health Care Market Oversight Program

Contractor shall comply with the Health Care Market Oversight (HCMO) Program relating to mergers, acquisitions, and other business transactions involving health care entities, including CCOs, in accordance with ORS 415.500 through 415.900 and as regulated by OHA in accordance with the foregoing statutes and as further detailed in OAR Chapter 409, Division 70. Information about the HCMO Program is found at: https://www.oregon.gov/oha/hpa/hp/pages/health-care-market-oversight.aspx.

11. 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. 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. Secs. 11 through 17of 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 Secs. 11 through 17 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. 15 of this Ex. B, Part 8.

b. OHA will hold, and Contractor is encouraged to attend, monthly All Plan System Technical (APST) Meetings via teleconference. The APST Meetings are open to all CCOs for the purpose of addressing ongoing 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. 13 and 14 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 Sec. 11, 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.

12. 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,[46] OAR 943-120-0100 through 943-120-0200 and as more specifically as set forth below in this Sec. 12 and Secs. 13-14 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.

[46] This existing OAR will be updated effective 1/1/2026.

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.

e. Contractor shall ensure that Encounter Data includes the Fee-for-Service Equivalent Value for each procedure code billed on a Provider's claim for healthcare services. Such Value shall be reported consistent with the Fee-for-Service Equivalent Value Guidance Document provided on the CCO Contract Forms Website.

13. Additional Encounter Data Submission Requirements: Non-Pharmacy Encounter Data

a. In accordance with Sec. 11, Paras. a.-f, and Sec. 12 above of this Ex. B, Part 8, Contractor shall submit all valid unduplicated Non-Pharmacy Encounter Data to OHA within forty-five (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. 11, Para. 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. 12 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. 11, Para. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

14. Pharmacy Encounter Data

a. In accordance with Sec. 11, Paras. a.-f, and Sec. 12 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. 11, Para. 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 Pharmacy Encounter Data processed. Notification of all Pharmacy Encounter Data that must be corrected will be provided to Contractor each week. Pharmacy Encounter 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. 12 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. 11, Para. m above of this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

15. Administrative Performance Standard

a. OHA has implemented an Administrative Performance (AP) 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. 10-13 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 Sec. 15 of this Ex. B, Part 8.

b. OHA may provide further instructions about the AP Standard and AP Withhold calculation methodology. The AP 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. 15, Ex. B, Part 8, after the: (i) conclusion of any appeal undertaken under Sub.Para. (4) above of this Para. c, Ex. B, Part 8, or (ii) expiration of time to request an appeal, OHA will provide Contractor's Contract Administrator with Administrative Notice of the amount of the AP Withhold owing by Contractor. In general, OHA will set-off the AP Withhold amount for the applicable Subject Month from the following calendar month's Capitation Payment.

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

16. 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 ACA (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. 3, 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 Pharmacy Encounter Data to OHA in accordance with Secs. 12 and 14 above of this Ex. B, Part 8 and this Sec. 15, 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.

17. 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.

18. Third Party Liability, Excluding Personal Injury Liens

a. For the purposes of this Sec. 18, references to Third Party Liability, except where expressly stated otherwise, exclude circumstances where the Member was injured by tortious conduct of a third party. Requirements regarding Members injured by tortious conduct are covered in Sec. 19, Personal Injury Liens, unless expressly stated otherwise.

b. If a Member has other insurance coverage, including personal injury protection under a motor vehicle insurance policy, 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.

c. 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.

d. 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 (18^{th}) month from the date the claim(s) was paid, at which point, OHA shall have the right to pursue recovery.

e. After the end of the twenty-fourth (24^{th}) 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.

f. Contractor shall develop, implement, and maintain written policies and procedures (P&Ps) regarding Third Party Liability recovery (TPLR). The TPLR P&Ps must be provided as a document separate from the Personal Injury Liens (PIL) P&Ps described in Sec. 19 of Ex. B, Part 8 and 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 or copies of the front and back of the TPL insurance card;

(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 paid the claim.

(2) The requirement of Contractor to report any and all TPL to OHA in the timeframes identified in this Sec. 18;

(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) The requirement of Contractor to adjust Encounter Data to reflect the amount received or recovered from the Third Party Payer; and

(6) 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.

g. Contractor shall submit its TPLR P&Ps to OHA within five (5) Business Days of the request and in the manner and to the location identified by OHA in the request.

h. Contractor's TPLR P&Ps must comply with this Contract and Applicable Laws, including but not limited to the Third Party Liability recovery requirements 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; ORS 743B.470; ORS 659.830; and OAR 416.510 to 416.610.

i. In order to meet its obligations under this Sec. 18, Contractor shall include in its Member Handbook the content from its TPLR P&Ps about the obligation of Members to provide information to, and cooperate with, Contractor. The content regarding such Member obligations shall, when included in the Member Handbook, conform to the accessibility requirements described in the Member Handbook evaluation guidance 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 Potential Members before and during Enrollment; and

(2) To all Members within thirty (30) days after any material change to Contractor's TPLR P&Ps.

j. 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#.

k. 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#.

l. OHA may require Contractor to provide the information required to be reported under Paras. j. or k, or both, of this Sec. 18, 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.

m. 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.

n. 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 of such coverage for a Member. Reporting must be made online at the URL identified above in Para. j of this Sec. 18, 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.

o. 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.

p. 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 of Exhibit L Financial Report Template (See Sec. 3, Ex. L).

q. Contractor shall adjust any Encounter Data within the timeframes specified under Secs. 11-14 above of this Ex. B, Part 8 to reflect Third Party Liability recoveries for such Encounter Data.

r. 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.

s. 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.

19. Personal Injury Liens

a. The Personal Injury Liens (PIL) Unit of the Office of Payment Accuracy and Recovery (OPAR) of ODHS is authorized pursuant to OAR 461-195-0303 to administer the Personal Injury Lien program for OHA and ODHS.

b. Contractor shall develop, implement, and maintain written policies and procedures (P&Ps) regarding Personal Injury Liens. Contractor's PIL P&Ps shall comply with this Sec. 19 of the Contract and applicable statutes and rules for the Personal Injury Lien program. The PIL P&Ps must be provided as a document separate from the TPLR P&Ps described in Sec. 18 of Ex. B, Part 8. The PIL P&Ps must include, at a minimum, all of the following:

(1) 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;

(2) Any thresholds for determining whether to obtain a lien assignment; and

(3) And any other requirements as may be identified by PIL.

c. Contractor shall submit its PIL P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

d. Contractor shall include in its Member Handbook the same content from its PIL P&Ps regarding the obligation of Members to provide information to, and cooperate with, Contractor in order for Contractor to meet its obligations under this Sec. 19, Ex. B, Part 8. The content regarding such Member obligations shall, when included in the Member Handbook, conform to the accessibility requirements described in the Member Handbook evaluation guidance located on the CCO Contract Forms Website. Contractor shall provide its Members with the applicable PIL content, or an updated Member Handbook with the applicable PIL content included, as follows:

(1) To Potential Members before and during Enrollment; and

(2) To all Members within thirty (30) days after any material change to Contractor's PIL P&P.

e. 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.

f. Contractor shall inform the PIL Unit 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, including personal injury protection under a motor vehicle insurance policy, 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.

g. In no event shall Contractor request or require a Member to execute a trust agreement or loan receipt, subrogation agreement, or other similar arrangement to guarantee reimbursement of Contractor. Contractor's only right to reimbursement is to obtain a lien assignment from the Personal Injury Liens Unit.

h. 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 and OAR 461-195-0301 through 461-195-0325, 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 was perfected. Contractor has no authority to sell or otherwise transfer its rights in the assigned lien, except to OHA or its designee. Contractor may contract with a third party to act as an agent on behalf of Contractor; however, Contractor shall retain ownership of the lien.

i. When Contractor is aware of a Third Party that may be legally liable for medical expenses paid by Contractor for a Member, Contractor shall request a lien assignment from the PIL Unit within thirty (30) days of receiving notice 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 a liable third party;

(5) Liable third party name and address; and

(6) Under comments of the online form, indicate "Request Lien Assignment."

j. 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 specified 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.

k. 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.

l. 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.

m. 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. Contractor or its Subcontractor shall respond to the PIL Unit's correspondence within five (5) Business Days of receipt.

n. 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 off-set 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.

o. 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.

p. 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 and any designated Assistant Attorney General 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 or Assistant Attorney General to communicate and work directly with any Subcontractor to efficiently undertake and manage any personal injury lien 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.

q. 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 410-141-3810. When a Member is retroactively Disenrolled under this Para. ~~r~~q, Sec. 19, 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.

r. Contractor shall comply with 42 USC § 1395y(b) and 42 CFR Part 411, Subparts C-E, which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or its Subcontractors.

s. 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 negotiated claim before any other entity, including Contractor or its Subcontractors, may be paid.

t. 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.

u. 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.

v. 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.

w. When engaging in Personal Injury 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 Personal Injury recovery actions a purpose that is directly connected with the administration of the Medicaid program.

x. Contractor shall report to OHA all amounts recovered from the assignment of a Personal Injury Lien. Reporting shall be included on the Exhibit L Financial Reporting Template.

y. Contractor shall take all reasonable actions to pursue recovery of Personal Injury Liens for Covered Services provided to a Member. Generally, tort actions must be commenced within 2 years of the tort. The PIL Unit may, eighteen (18) months after the date of a potential tort injuring a Member, revoke a lien assignment and pursue the lien. Contractor will execute any documents needed to revoke or assign the lien to the PIL Unit. Contractor will cooperate with the PIL Unit and provide any information the PIL Unit needs to pursue the lien, including cooperation with any litigation.

z. The PIL Unit will provide Contractor with all personal injury information available to the PIL Unit to assist in the pursuit of financial recovery as it pertains to Personal Injury Liens.

20. Disclosure of Ownership Interests

a. Contractor shall provide OHA with the disclosures required in this Sec. 20, Ex. B, Part 8 in accordance with the details set forth in Paras. b-c below of this Sec. 20, Ex. B, Part 8. The disclosures under Secs. 20-21, 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 Para b, Sec. 20, Ex. B, Part 8.

(3) The FEIN or other tax identification number for every entity disclosed under Sub.Para. (1) above of this Para. b, Sec. 20, 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. 20, 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. 20, 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. 20, 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. b, Sec. 20, 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. 20, 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, using the form provided by OHA;

(2) Subject to Sec. 22 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, using the form provided by OHA; and

(3) Upon request by OHA, using the form provided 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. (3), Para. c, Sec. 20, 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.

21. Disclosure of Other Ownership Interests

In addition to the disclosures Contractor is required to make under Sec. 20 above of this Ex. B, Part 8, Contractor shall also make all of the disclosures required under this Sec. 21, 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. 21, Ex. B, Part 8.

c. Disclosures required to be made under this Sec. 21, 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.

22. 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 410-141-5310 and 410-141-5315) and therefore is not subject to prior written notice to and approval by OHA (OAR 410-141-5320 and 410-141-5325).

(1) Contractor must also comply, as applicable, with OAR 409-070-0000 through 409-070-0085.

b. Contractor shall provide Administrative Notice 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 one hundred twenty (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. 19.

e. As a condition precedent to obtaining OHA's approval of a transfer, Subcontract, assignment, or sale under Para. d above of this Sec. 22, 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 Sub.Para. (2), 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.

23. 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.

24. 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.

[Remainder of page intentionally left blank]

Exhibit B – Statement of Work – Part 9 – Program Integrity

1. Monitoring and Compliance Review - Overview

a. OHA is responsible for Monitoring 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; and (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 (CAP) 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 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. 12, Para. a, Sub.Para. (7), a breach of the requirements of this Contract by a Subcontractor shall be deemed a breach by 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 Law or as required under this Contract;

(2) Imposes premiums or charges on Members that are in excess of the premiums or charges permitted under this Contract or Applicable 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 Assessment and Performance Improvement Program, or to provide timely reports and data in connection with 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, or record 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 any of the other applicable requirements of Sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations;

(17) Violates any of the other applicable requirements of 42 USC § 1396b(m) or § 1396u-2 and any implementing regulations;

(18) Fails to comply with State or federal information security or privacy laws; or

(19) Violates any or all of the program integrity requirements as those requirements are set forth in 42 CFR Part 438 Subpart H and this Contract including, without limitation:

(a) The failure to open a Program Integrity (PI) Audit within twenty (20) Business Days after receiving written Notice of Potential At-Risk Overpayment from OHA's Office of Program Integrity (OPI) as required in Sub.Para. (3), Para. b of Sec. 15 below of this Ex. B, Part 9.

(b) The failure to open a PI Audit within twenty (20) Business Days after receiving notification of a potential Overpayment from any internal or external source as required in Sub.Para. (3), Para. b of Sec. 15 below of this Ex. B, Part 9.

(c) The failure to provide to OPI a written final PI Audit report with all Encounter Data and information required in Sub.Para. (3), Para. b of Sec. 15 below this of Ex. B, Part 9.

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 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,

(7) Those Sanctions specified in OAR 410-141-3531 for failure to comply with State or federal information security or privacy laws, or

(8) Other Sanctions as permitted under OAR 410-141-3530, which may include, without limitation:

(a) Assessment of a recovery amount equal to one percent (1%) of Contractor's last total monthly Capitation Payment immediately prior to imposition of the Sanction. Such amount will be set-off from Contractor's next total monthly Capitation Payment;

(b) Require Contractor to develop and implement a CAP that is acceptable to OHA for correcting the problem;

(c) Where financial solvency is involved, actions may include increased reinsurance requirements, increased reserve requirements, market conduct constraints, or financial examinations; or

(d) Civil money penalties in addition to those identified in 42 CFR § 438.704.

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

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 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. b 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;

(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 or Notice of Appeal Resolution or both 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 bi-annual DSN Provider Capacity Report or annual DSN Report or both 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
(13)	Failure to open a PI Audit or provide a copy of the final PI Audit report to OHA or both	$250 per day for each day beyond the due date specified
(14)	Failure to open a PI Audit following OPI Notice of Potential At-Risk Overpayment or provide a copy of the required final PI Audit report or both	$250 per day for each day beyond the due date specified

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 in 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 Administrative Notice of its intent to impose Sanction(s). OHA will send such Notice to the email address for Contractor's Contract Administrator and copied to the email address for Contractor's Chief Executive Officer, if different from the Contract Administrator. The Administrative Notice will explain the factual basis for the Sanction(s), reference to the applicable Section(s) of this Contract or Applicable 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 Administrative Notice of Sanction, a request for Administrative Review to be conducted in accordance with OAR 410-120-1580 with 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 Administrative Notice of Sanction as described in Para. a. above, OHA will offset 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(3)-(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 Secs. 11-20 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 Secs. 12-20 below of this Ex. B, Part 9. (These Subcontractors are exempt from the requirements of Sec. 11 below.) With respect to the requirements in Secs. 12-20 below,

a prospective or existing Subcontractor's or Participating Provider's attestation of compliance may not replace Contractor conducting, as applicable, a pre-contracting readiness review or a formal annual compliance review.

11. Contractor's Unit Responsible for Program Integrity Operations

a. Contractor shall establish and maintain investigatory and Program Integrity (PI) Audit capacity necessary to detect potential Fraud, Waste, and Abuse in accordance with all applicable requirements and standards under this Contract, Applicable Laws, and State guidance.

b. To implement the PI Audit and investigation requirements of this Contract, Contractor shall establish and maintain the minimum count(s) and type(s) of Full Time Employees (FTE Employees) specified in the table below, in addition to a Chief Compliance Officer.

(1) Contractor shall have the number of FTE Employees that is proportionate to Contractor's maximum Enrollment limit (as specified in Sec 3.2 of the General Provisions) to perform PI Audits and investigations of payments made by Contractor for all services under this Contract to Participating Providers, Subcontractors, and other third parties, regardless of whether the services or goods were paid using an encounter claim, invoice, or a capitated payment arrangement; and

(2) Each FTE Employee must be an investigator or auditor as specified in the table below and shall be dedicated to Contractor's PI Audits and investigations.

Maximum Enrollment Limit	Minimum Dedicated FTE Employee(s)	Type of Employee(s)	Chief Compliance Officer
1 to 50,000	1 FTE	Investigator or auditor	1 Chief Compliance Officer
50,001 to 100,000	2 FTE	1 FTE investigator and 1 FTE auditor	
100,001 to 200,000	3 FTE	1 FTE investigator and 2 FTE auditors	
200,001 to 300,000	4 FTE	1 FTE investigator and 3 FTE auditors	
300,001 to 400,000	5 FTE	1 FTE investigator and 4 FTE auditors	
400,001 to 500,000	6 FTE	1 FTE investigator and 5 FTE auditors	
500,001 to 600,000	7 FTE	2 FTE investigators and 5 FTE auditors	

c. Contractor's organizational structure for these FTE Employees may be organized as one centralized division, department, Special Investigation Unit (**"SIU"**), or team, or decentralized, or assigned part-time or full time, as long as the total minimum count(s) and type(s) of required FTE in the table above are met.

d. Regardless of the organizational structure adopted by Contractor, centralized or decentralized, the PI Audit and investigation operations of Contractor and the activities performed by such FTE Employees must be dedicated to this Contract, and these employees must meet the qualifications

established by Contractor in the position description for each role (auditor or investigator) to be counted towards meeting the FTE requirements specified above.

e. Contractor Delegation to a Subcontractor:

(1) Contractor shall not count a one (1) FTE Employee who performs PI Audits or investigations for another entity or organization with which Contractor contracts, including Contractor's Subcontractor or other CCO, toward meeting the above Para. b requirements unless the employee is dedicated one (1) FTE to Contractor's PI Audits and investigations for this Contract.

(2) When Contractor applies a Subcontractor's employees to meet the FTE Employees requirement in Para. b above, Contractor must include in the Subcontract information detailing this Delegation. Contractor is responsible for verifying and monitoring that the Subcontractor maintains FTE Employees that meet the requirements of this Ex. B, Part 9 and taking prompt corrective action(s) as necessary to correct Subcontractor non-compliance.

f. The requirements of this Sec.11 are not intended to limit or otherwise prevent Contractor from hiring for more FTE Employees than the minimum required under Para. b as needed to meet Contractor's investigative or PI Audit demands.

g. Contractor shall include in its FWA Prevention Handbook, as required under Sec. 12 of Ex. B, Part 9, documentation that provides evidence of compliance with the requirements of this Sec. 11. When Contractor counts the FTE Employees, Contractor must describe how roles and work are apportioned, hiring practices and qualifications, and define the scope of each FTE Employee's role within Contractor's policies and procedures and in the position description Contractor develops for these FTE Employees. Necessary documentation may include without limitation a combination of policies and procedures, a position description, contracts or other agreements, employee training/education record or professional certifications, or other documentation of work history such as an employment verification letter or offer letter which includes the date(s) of employment and position.

12. 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. Contractor shall submit its FWA Prevention Handbook to OHA within thirty (30) days of OHA's request and in the manner and to the location identified by OHA in the request.

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. 12, Ex. B, Part 9, and (ii) creating the Annual FWA Prevention Plan (as such Plan is described in Sec. 13 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 professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor.

(a) Contractor's division, department, SIU, or team shall also meet the requirements set forth in Sec. 11, Ex. B Part 9;

(b) Contractor must demonstrate continuous work towards increasing qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees;

(c) The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care Providers; and

(d) The team may employ, or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases.

(4) Criteria developed and implemented to perform routine internal Monitoring and routine evaluation of Subcontractors and Participating Providers for other related compliance risks;

(5) A statement or narrative that articulates Contractor's commitment to complying with the terms and conditions set forth in Secs. 1-20 of this Ex. B, Part 9 and all other Applicable Laws;

(6) 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 Laws;

(7) A description of Contractor's disciplinary guidelines used to enforce compliance standards and how those guidelines are publicized;

(8) 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 suspected Fraud, Waste, or Abuse. Contractor's system for training and education must provide all information necessary for its employees, Subcontractors and Participating Providers to fully comply with the Fraud, Waste, and Abuse requirements of this Contract. All such training and education must be specific and applicable to suspected Fraud, Waste, and Abuse in the Medicaid program. All training must include Medicaid-specific referral and reporting information and training regarding Contractor's Medicaid Fraud, Waste, and Abuse policies and procedures, including any time parameters required for compliance

with Ex. B, Part 9. 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 as well as all members of its board of directors;

(9) In addition to the training and education required under Sub.Para. (8) above of this Para. b, Sec. 12, 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;

(10) Systems designed to maintain effective lines of communication between Contractor's Compliance Office and Contractor's employees and Subcontractors;

(11) 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 Laws, including policies for when Contractor may perform an on-site visit for PI Audits and investigations of Participating Providers;

(12) Procedures for reporting potential or suspected (or both) Fraud, Waste, and Abuse to the appropriate agencies in accordance with Sec. 18 below of this Ex. B, Part 9;

(13) Provisions that provide detailed information about the State and federal False Claims Acts and other Applicable Laws, including, as provided for Section 1902(a)(68) of the Social Security Act and the protections afforded to those persons who report suspected Fraud, Waste, and Abuse under applicable whistleblower laws. The disclosures described in this Sub.Para. (13) 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;

(14) Procedures to routinely verify whether services that have been represented to have been delivered by Participating Providers and Subcontractors were received by Members, to investigate incidents where services were not delivered or where Member paid out of pocket for services, and to collect any associated Overpayments. Such verification of services must be made by: (i) mailing service verification letters to Members, (ii) sampling, or (iii) other methods;

(15) 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;

(16) 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;

(17) Provisions for Contractor to conduct PI Audits and 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 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, or 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. 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.

(b) If Overpayment was identified by Contractor at any time in the course of a PI Audit or investigation and the Overpayment is due to suspected or potential (or both) Fraud, Waste or Abuse, such Overpayment must, in accordance with Paras. d and e of Sec. 18 below of this Ex. B, Part 9, be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment.

(c) If Overpayment was identified by Contractor as a result of a PI Audit or investigation:

i. The Total Overpayment Alleged in the Final PI Audit Report must be reported by Contractor to OHA promptly, but in no event more than thirty (30) days, as required under 42 CFR § 438.608(a)(2). Contractor shall report such Overpayment to OHA in a final PI Audit Report, in accordance with Sec. 15, Para. b. and Sec. 18 below of this Ex. B, Part 9.

ii. The recovered Overpayment must be reported by Contractor to OHA promptly, but in no event more than thirty (30) days after the date that Contractor recovers the Overpayment, as required under 42 CFR § 438.608(a)(2). Contractor shall report such Overpayment to OHA in a final PI Audit Report, in accordance with Sec. 15, Para. b. and Sec. 18 below of this Ex. B, Part 9.

(18) In addition to the procedures for reporting required under this Ex. B, Part 9, Contractor shall develop and maintain a procedure for accurately reporting all Overpayments on its semi-annual and annual Financial Reports as required under Sec. 4, 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. (16) and (17) above of this Para. b, Sec. 12, Ex. B, Part 9, (ii) the result of a routine or planned PI Audit, or (iii) the result of a PI Audit under Sub.Para. (22) below or other review;

(19) A process for Members to report potential or suspected (or both) Fraud, Waste or Abuse anonymously and to be protected from retaliation under applicable whistleblower laws;

(20) 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

(21) 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.

(22) Policies and procedures pursuant to which Contractor shall perform PI Audits required under Sec. 15 below of this Ex. B, Part 9 when Contractor:

(a) Receives a written Notice of Potential At-Risk Overpayment from OPI; or

(b) Is notified of a potential Overpayment by an employee, Subcontractor, Provider, Member, or any other internal or external source.

(23) Procedures for Contractor to respond within five (5) Business Days to a written request from OPI for additional information or Encounter Data about any PI Audit conducted by Contractor or its Subcontractor. Contractor shall, and shall contractually require all of its Subcontractors to, in addition to those requirements set forth in Ex. B, Part 4, Sec. 12, Para. b, Sub.Para. (1), Sub-Sub.Paras. (k) and (l), comply with all of the following:

(a) Contractor and its Subcontractor(s) shall:

i. Maintain records, including records of all PI Audits and investigations relating to suspected Fraud, Waste, and Abuse or Overpayments. The records must include the detail necessary to substantiate all actions taken and outcome(s) reached for each PI Audit or investigation for this Contract.

ii. Allow access to all PI Audit and investigation supporting documents, information, systems, and facilities in accordance with Ex. B, Part 9, Sec. 18 and Ex. D, Sec. 15 of this Contract.

(b) Contractor must not Delegate to its Subcontractors Contractor's obligation under this Sub.Para. (23) to respond to an OPI request for additional information or Encounter Data about a PI Audit or investigation. Contractor must send a response to OPI within five (5) Business Days regardless of whether the records requested are maintained by Contractor or maintained separately with one or more of Contractor's Subcontractors.

(24) Procedures pursuant to which Contractor shall send OPI copies of all PI Audit files, Encounter Data, and other PI Audit supporting documentation in any form and criteria used for the PI Audit as required by Sec. 20 of this Ex. B, Part 9.

(25) Policies and procedures pursuant to which Contractor shall review all PI Audit(s) performed by its Subcontractors. Contractor shall evaluate its Subcontractors' completed final PI Audit reports to determine whether they are complete, accurate, and include all of the information required under Para. b, Sec.15 below of this Ex. B, Part 9.

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 potential or suspected (or both) Fraud, Waste, and Abuse; and

(4) A Member's right to report potential or suspected (or both) Fraud, Waste, and Abuse anonymously, and to be protected under applicable whistleblower laws.

13. 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 activities listed below. Contractor's written plans must address what measures, criteria, or method(s) Contractor will use to evaluate effectiveness.

(1) PI Audits and other related compliance issues:

(a) Routine internal Monitoring, reporting, and PI Auditing of Fraud, Waste, and Abuse risks. Contractor must provide a work plan which lists all PI Audits planned for the Contract Year, identifies individual(s) or department resources used to conduct the reviews, data or information sources, whether each review is conducted in person/on-site, and when each review is scheduled to begin;

(b) Routine internal Monitoring, reporting, and auditing of other related compliance risks. Contractor must provide a work plan which lists all compliance reviews planned for the Contract Year, identifies individual(s) or department resources used to conduct the reviews, data or information sources, whether each review is conducted in person/on-site, and when each review is scheduled to begin;

(c) Prompt response to potential or suspected (or both) Fraud, Waste, and Abuse as they are reported or otherwise discovered. Contractor identifies its methods used to: receive allegations; track, triage, and refer (i) to MFCU/OPI for fraud or abuse or (ii) to internal quality or compliance department(s); and investigate, resolve, and refer final case internally for further compliance, Corrective Action, or open a PI Audit to recover Overpayments. Contractor is prohibited from referring allegations to a Subcontractor who is also a party to the allegation;

(d) Prompt response to other related compliance issues as they are reported or otherwise discovered. Contractor identifies its methods used to: receive allegations; track, triage, and refer (i) to MFCU/OPI for fraud or abuse or (ii) to internal quality or compliance department(s); and investigate, resolve, and refer final case internally for further compliance, Corrective Action, or open a PI Audit to recover Overpayments;

(e) Investigation of potential Fraud, Waste, and Abuse as identified in the course of self-evaluation and PI Audits;

(f) Investigation of other related compliance problems as identified in the course of self-evaluation and PI Audits;

(g) Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of Fraud, Waste, and Abuse in a manner that is designed to reduce the potential for recurrence;

(h) Prompt and thorough correction (or coordination of suspected criminal acts with law enforcement agencies) of any and all incidents of other related compliance problems in a manner that is designed to reduce the potential for recurrence;

(i) Activities that support ongoing compliance with the Fraud, Waste, and Abuse prevention under this Contract;

(j) Activities that support ongoing compliance with other related compliance requirements under this Contract.

(2) Risk evaluation procedures to enable compliance in identified problem areas such as claims, Prior Authorization, service verification, utilization management and quality review. Contractor's annual risk evaluation/assessment must identify a methodology for assessing risk of Fraud and the likelihood and impact of potential Fraud. The Fraud risk assessment may be integrated into Contractor's overall compliance risk assessment or be performed separately from Contractor's overall compliance risk assessment; and

(3) The development and implementation of an annual plan to perform PI Audits of Providers and Subcontractors that will enable Contractor to validate the accuracy of Encounter Data against Provider charts.

14. Review and Approval of Annual FWA Prevention Plan

a. Contractor shall annually review and update its Annual FWA Prevention Plan and submit it to OHA, via Administrative Notice, for review and approval by no later than January 31 of each Contract Year. Contractor's Annual FWA Prevention Plan must not be implemented or distributed prior to approval by OHA. Contractor must utilize the FWA review template provided by OHA on the CCO Contract Forms Website and include the completed template with its Annual FWA Prevention Plan submission. OHA will notify Contractor, via Administrative Notice, within ninety (90) days from the due date, or within ninety (90) days from the received date if after the due date, of the compliance status of its Annual FWA Prevention Plan. In the event OHA disapproves the Annual FWA Prevention Plan for failing to meet the terms and conditions of this Contract and any other Applicable 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 by July 19 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. After OHA's initial approval of Contractor's Annual FWA Prevention Plan under Para. a. of this Sec. 14, Ex. B, Part 9, Contractor shall also submit such Plan 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 after initial approval by OHA. OHA will notify Contractor within ninety (90) days from receipt of the compliance status of the revised Annual FWA Prevention Plan. In the event the revised Annual FWA Prevention Plan 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 within thirty (30) days of OHA request in the manner

requested by OHA. OHA will notify Contractor within ninety (90) days from the due date, or within ninety (90) days from the received date if after the due date, of the compliance status of the policy. In the event the revised Annual FWA Prevention Plan is 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.

15. OHA and Contractor Program Integrity Audits of Network Providers

a. Audits Performed by OHA

(1) If OHA conducts an audit of Contractor's Participating Provider(s), or Subcontractor(s), or the Provider's or Subcontractor's 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 Provider(s) and Subcontractor(s). 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.

(2) 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 Provider(s) or Subcontractor(s) will follow the process outlined in OAR 410-120-1396. Contractor may appeal an Overpayment determination by submitting a written request to OHA's Office of Program Integrity (OPI) within thirty (30) calendar days from the postmark date or date of email of the final audit report. Appeals will be conducted by OPI in the manner described in OAR 410-120-1396.

(3) In accordance with OAR 410-120-1396, 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 Provider(s) or Subcontractor(s), 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 ODHS, OHA, OPI, or DOJ about the same or similar improper billing practices.

(4) If OHA conducts an audit of Contractor's Provider(s) or Subcontractor(s) or the Provider's or Subcontractor's 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.

b. PI Audits Performed by Contractor or its Subcontractors

(1) If Contractor or its Subcontractor(s) conducts PI Audits of Contractor's Providers or Provider's Encounter Data that results in a finding of Overpayment, Contractor is permitted to keep any sums recovered.

(2) Recoveries that are retained by Contractor shall be reported to OHA as set forth in this Ex. B, Part 9 and Ex. L.

(3) All PI Audits performed by Contractor must be opened within twenty (20) Business Days after Contractor receives a written Notice of Potential At-Risk Overpayment from OPI or Contractor is notified of a potential Overpayment by an employee, Subcontractor, Provider, Member, or any other internal or external source. All PI Audits conducted by Contractor under this Sec. 15 shall be comprised of all the tasks and activities identified below in Sub-Sub.Para. (a) and provide at the close of the PI Audit a written final PI Audit final report as identified below in Sub-Sub.Para. (b).

(a) Each PI Audit shall include all of the following:

i. Validate or verify the following information about the Provider (Provider entities as well as billing Providers and individual rendering Providers as may be applicable):

A. Provider name(s);

B. All applicable Provider Medicaid Identification Number(s) and all enrollment file data (e.g., Provider address(es), all practice location(s), and, as applicable for the Provider type, the TIN/SSN/EIN, NPI, and taxonomy codes);

C. Member(s) name(s) and Medicaid ID number, as applicable;

D. Oregon business registration status, legal business name, and, if applicable, assumed business name;

E. Exclusion status of Provider(s) (LEIE & SAM) and any person(s) with ownership or control interest (including all managing employees), as these terms are defined by 42 CFR 455.101;

F. Provider license(s) and billing and rendering provider(s), as applicable;

G. Provider certification(s).

ii. Collect information about the billing issues identified;

iii. Select a PI Audit focus or question, including the billing code(s) selected for review;

iv. Review all Encounter claims or a statistically valid sample of Encounter claims;

v. Review clinical or other financial records;

vi. Identify Overpayment, Total Overpayment Alleged in a Final PI Audit Report, or other audit findings;

vii. Outcome(s) of a Provider appeal of the audit findings; and

viii. Overpayment recovery, repayment plan, or other corrective action to prevent future Overpayments.

(b) Information required to be documented in each final PI Audit report:

i. The information gathered about the Provider(s) under Sub-Sub.Para. (a) above of this Sub.Para. (3);

ii. The date range of the Encounter claims audited;

iii. PI Audit focus or question, including the billing code(s) selected for review;

iv. Summary table: Data mining and report on the universe and sample of Encounters audited; the clinical or financial records reviewed;

v. Referrals made by Contractor to licensing boards or other state or federal regulatory entities;

vi. Summary of audit criteria applied and the resulting financial and other relevant findings;

vii. Total Overpayment Alleged in the Final PI Audit Report;

viii. The outcome of any Provider appeal(s), as applicable;

ix. Summary of Overpayments recovered, repayment plan, and other Provider corrective action(s) or education or both to prevent future Overpayments by Contractor and the disposition of the PI Audit; and

x. Other relevant audit findings as Contractor deems necessary.

c. All audits or PI Audits conducted by OHA or Contractor shall be conducted in accordance with the terms and conditions of the Contract that was or is in effect for the period of time the audit(s) cover. Recoupment and recoveries from Contractor as a result of audits will be in accordance with the terms and conditions of the Contract and the federal and state Medicaid rules that were or are in effect for the period of time the audit(s) cover.

16. 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. 12, 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. 11-13 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 conducts PI Audits of its Providers, Subcontractor(s), 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 Para. b, Sec. 15 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. 16 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.

17. 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.

18. 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 included 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 Enrollment Unit via Administrative Notice.

b. Using the template provided by OHA 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 PI Audits performed. The Annual and Quarterly FWA Audit Reports must include all data points listed in the template, information on all Provider Overpayments that were identified or recovered (or both) as required under 42 CFR § 438.608(d)(3), the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by Contractor on its Subcontractors or Providers. For both the Quarterly and Annual FWA Audit Reports, Contractor must report all PI Audits opened, in-process, and closed during the reporting period. Contractor shall also provide to OHA with each Quarterly FWA Audit Report a copy of the final PI Audit report which meets the requirements of Para. b, Sub.Para. (3), Sub-Sub.Para. (b) above of Sec. 15 of this Ex. B, Part 9 for each PI Audit identified in the Report as closed during the reporting quarter as well as any other final PI Audit Reports that have not been submitted.

(1) Contractor shall submit the Annual FWA Audit Report to OHA, via Administrative Notice, by January 31 of each Contract Year following the reporting year.

(2) Contractor shall submit each Quarterly FWA Audit Report to OHA, via Administrative Notice, within thirty (30) days following the end of each calendar quarter.

(3) Contractor shall also report Overpayment data, as required under 42 CFR § 438.608(a)(2), to OHA in a final PI Audit report that meets the requirements of Para. b, Sub.Para. (3), Sub-Sub.Para. (b) above of Sec. 15 of this Ex. B, Part 9. Contractor's final PI Audit report is due to OHA promptly, but not more than thirty (30) days following the date:

(a) Of the Total Overpayment Alleged in the Final PI Audit Report.

(b) The Overpayment is recovered.

(4) OHA review of Contractor's Reports:

(a) OHA's OPI will notify Contractor, via Administrative Notice, within sixty (60) days from the due date, or within sixty (60) days from the received date if after the due date, of the compliance status of its Annual FWA Audit Report. In the event OHA disapproves of the Annual FWA Audit Report (including one or more of Contractor's final PI Audit reports for audits identified in the Annual FWA Audit Report as closed) for failing to meet the terms and conditions of this Contract and any other Applicable Laws, Contractor shall, in order to remedy the deficiencies, follow the process set forth in Sec. 5, Ex. D of this Contract.

(b) In addition, OHA's OPI may review Contractor's Quarterly and Annual FWA Audit Reports and copies of final PI Audit reports and request PI Audit supporting documents, as outlined in Sec. 20 of this Ex. B, Part 9.

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. 17 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) Contractor shall submit the Annual FWA Referrals and Investigations Report to OHA, via Administrative Notice, by January 31 of each Contract Year following the reporting year.

(2) Contractor shall submit each Quarterly FWA Referrals and Investigations Report to OHA, via Administrative Notice, within thirty (30) days following the end of each calendar quarter.

(3) OHA review of Contractor's Reports:

(a) OHA's OPI will notify Contractor, via Administrative Notice, within sixty (60) days from the due date, or within sixty (60) days from the received date if after the due date, of the compliance status of its Annual FWA Referrals and Investigations Report. In the event OHA disapproves of the Annual FWA Referrals and Investigations Report for failing to meet the terms and conditions of this Contract and any other Applicable Laws, Contractor shall, in order to remedy the deficiencies, follow the process set forth in Sec. 5, Ex. D of this Contract.

(b) In addition, OHA OPI may review Contractor's Quarterly and Annual FWA Referrals and Investigations Reports and request case investigation supporting documents, as outlined in Sec. 20 of this Ex. B, Part 9.

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 (i.e., referrals) 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. 18, Ex. B, Part 9.

(1) Contractor and any Subcontractor sending a referral to OPI and MFCU of suspected Provider FWA or issues with the characteristics of those in Sec. 17 above of this Ex. B, Part 9 shall use the FWA Referral Form provided by OHA (available on the CCO Contract Forms Website). The FWA Referral Form must, when sent to OPI and MFCU, include, at a minimum, the following information:

(a) Contractor's name;

(b) Name of Provider or Member;

(c) The suspected issue or allegation;

(d) The information or data Contractor has already reviewed; and

(e) Planned next steps for further investigation.

(2) Contractor shall include, and require all Subcontractors to include, in each written communication or referral sent to OPI and MFCU the following:

(a) Contractor's name;

(b) Contractor's Medicaid contract number; and

(c) Which entity (Contractor or Subcontractor) and the name and title of the individual within the entity who is performing the investigation, PI Audit, or other review, and their contact information;

(d) Contractor may provide the above information to OPI by completing the FWA Referral Form.

(3) Individual whistleblowers or any other person(s) who make a report of suspected Fraud, Waste, Abuse, or non-compliance to Contractor or its Subcontractors shall not be required to use the FWA Referral Form or be required to include identifying information in their anonymous reports. All anonymous FWA reporting shall be accepted by Contractor, Subcontractors, and Participating Providers.

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. 17, of this Ex. B, Part 9. All reporting must be made as set forth below in Paras. h. and i. below, of this Sec. 18, Ex. B, Part 9.

f. Contractor shall cooperate in good faith with MFCU and OPI, or their designees, in any investigation or PI 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. 18, 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 faith with 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 CFR § 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 Participating Provider(s) or Subcontractor(s) or both, 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 Participating Provider(s) or Subcontractor(s). Subject to 42 CFR § 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 Participating Provider(s) or Subcontractor(s) if certain good cause exceptions are met as provided for under 42 CFR § 455.23(e). In the event OHA determines a credible allegation of Fraud has been made against a Participating Provider or Subcontractor, Contractor must cooperate with OHA to determine, in accordance with the criteria set forth in 42 CFR § 455.23, whether sums otherwise payable by Contractor to such Participating Provider or 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 via any of the methods listed below for MFCU and OPI:

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890
Secure email: Medicaid.Fraud.Referral@doj.state.or.us

OHA Office of Program Integrity (OPI)
500 Summer St. NE, E36
Salem, OR 97301
Secure email: OPI.Referrals@oha.oregon.gov
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 ODHS Fraud Investigation Unit (FIU). Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

ODHS 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/odhs/financial-recovery/Pages/fraud.aspx

(2) Contractor shall include the above contact information for the ODHS Fraud Investigation Unit in its FWA Prevention Handbook and its Member Handbook.

19. 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. Contractor shall implement a structured and constant process to assess, Monitor, and improve the quality and effectiveness of PI Audits and investigations. An effective Medicaid program integrity and risk management approach means that Contractor's program integrity program or SIU has internal controls to (i) prevent instances of Fraud, Waste, Abuse and other misconduct from occurring; (ii) detect instances of potential Fraud, Waste, Abuse and other misconduct; and (iii) respond appropriately when integrity breakdowns are identified.

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

(1) A high-level synopsis of the FWA investigations conducted by Contractor, lessons learned from these investigations, and strategies being employed to improve Contractor's FWA prevention program;

(2) A high-level synopsis of the Subcontractor and Participating Provider PI Audits conducted by Contractor in response to referrals and investigations and strategies being employed to improve Contractor's FWA prevention program;

(3) Compliance reviews conducted in response to reported or suspected non-compliance. Contractor must provide a concise summary for each Subcontractor and Participating Provider compliance review conducted by Contractor in response to reported or suspected non-compliance, including the rationale for conducting the review, whether the review was performed on-site or based on a review of documentation, outcome of the review, and any corrective action taken;

(4) Identify the training and education provided to and attended by Contractor's Chief Compliance Officer, all employees including senior management, Board of Directors, Providers, and Subcontractors during the prior Contract Year;

(5) Compliance and Fraud, Waste, and Abuse prevention operations that were performed during the prior Contract Year. The work and activities reported in the Annual Assessment Report must align with the Annual FWA Prevention Plan. The work and activities must be clearly described and be specific to the reporting year. Contractor shall include the information listed below in its annual assessment Report. For Sub-Sub.Paras. (a-g) below, Contractor shall provide such information for each program integrity activity or work conducted in the prior Contract Year:

(a) A high-level self-evaluation of the planned Provider PI Audit activities Contractor performed and whether such PI Audit activity was in accordance with Contractor's Annual FWA Prevention Plan from the prior Contract Year;

(b) A description of the methodology used to identify high-risk Providers and services;

(c) A summary of all planned compliance reviews performed by Contractor of its Subcontractors, Participating Providers, and any other third parties during the prior Contract Year which must include a (i) description of the data analytics relied upon, (ii) narrative of whether and how such activity was or was not performed in accordance with Contractor's Annual FWA Prevention Plan for the prior Contract Year, (iii) a narrative of the outcomes of the compliance reviews, and (iv) a copy of the corrective action plan for any required corrective action taken;

(d) Any applicable request for technical assistance from OHA, DOJ's MFCU, or CMS on improving the compliance activities performed by Contractor;

(e) A sample of the service verification letters mailed to Members; and

(f) A concise summary report on:

i. The number of service verification letters sent;

ii. How Members were selected to receive such letters;

iii. Member response rates;

iv. The frequency of mailings, including all dates on which such letters were mailed;

v. The results of the efforts; and

vi. Other methodologies used to ensure the accuracy of data.

(g) A narrative and other information that advises OHA of:

i. The outcomes of all FWA prevention activities undertaken by Contractor;

ii. Activities undertaken by Contractor to assess, monitor, and improve the quality and effectiveness (for the purposes of this report effectiveness is defined in Para. b. above of this Sec. 19) of PI Audits and investigations;

iii. Proposed or future process, policy, and procedure improvements to address deficiencies identified through FWA prevention operations conducted during the prior Contract Year; and

iv. With particularity, whether work or activities identified in its FWA Prevention Plan were or were not implemented in compliance with the descriptions included in Contractor's FWA Prevention Plan or were implemented differently than described in Contractor's FWA Prevention Plan, or both, and, if not performed in accordance with Contractor's FWA Prevention Plan, an explanation of how and why the FWA prevention activities changed.

d. Contractor's Annual FWA Assessment Report must be provided to OHA, via Administrative Notice, by no later than January 31 of Contract Year seven (2026). OHA will advise Contractor

of its reporting requirements for Contract Year nine (2028) at least one-hundred and twenty (120) days prior to the Contract Termination Date.

20. Additional OHA Provisions for Measuring Output and Reviewing Outcomes of Contractor's Program Integrity Operations

a. OPI has the right to use data from Contractor's Quarterly and Annual FWA Audit Reports and FWA Referrals and Investigations Reports described in Sec. 18, Paras. b and c above of this Ex. B, Part 9 to track the following information:

(1) Contractor program integrity case statistics:

(a) Open, closed and continuing cases; and

(b) Overpayments identified and overpayments recovered.

b. OPI may request additional information from Contractor as OPI deems necessary to verify data is accurate, complete, and meets the requirements of this Contract.

c. OPI may review Contractor's and Contractor's Subcontractor's final PI Audit reports and may request from Contractor additional audit files, data, or audit work papers as deemed necessary by OPI in its sole discretion to determine whether standard audit practices and principles were used in conducting the PI Audit and that the PI Audit complied with all requirements of Ex. B, Part 9.

(1) OPI has the right to request additional information and documentation from Contractor at any time.

(2) Contractor shall promptly respond to a request made by OPI under Sub.Para. (1) of this Para. c, but in all such instances such response(s) must be made within five (5) Business Days and provide copies of the requested information or document(s) to OPI within twenty (20) Business Days of a request.

(3) If Contractor is unable to submit part or all the requested information or documentation (or both) to OPI by the response due date, Contractor must contact OPI prior to such due date to discuss the issue(s). Subject to OPI's sole discretion, Contractor may be provided with an extension of time and new due date for producing the required information or documentation (or both) or OPI may take other actions, as appropriate. Contractor shall be solely responsible for responding to requests for information or documentation made by OPI (under this Sec. 20) and shall not Delegate this responsibility to any Subcontractor.

[Remainder of page intentionally left blank]

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 Quality Assessment and Performance Improvement program; (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, the State Quality Strategy, this Ex. B, Part 10, and other Applicable Law.

2. Quality Assessment and Performance Improvement Program and Quality Strategy Requirements

a. Contractor shall implement and maintain a comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services provided to Members. The QAPI program must set forth Contractor's methods and means for Monitoring progress and improvement and subsequent performance measure reporting related to quality improvement and quality assurance as required under, and in accordance with, the State Quality Strategy, OAR 410-141-3525,[47] and 42 CFR § 438.330.Contractor shall develop a process to evaluate the impact and effectiveness of its own QAPI program. OHA will work with Contractor to develop and implement Contractor's QAPI program, including processes necessary for Monitoring and evaluation, and identifying a deadline for the report required to be submitted to OHA under Para. b of this Sec. 2. The foregoing work will occur during Contract Year seven (2026).

b. OHA will evaluate Contractor's QAPI program on an annual basis to assess the impact and effectiveness of the program. The review will include:

(1) Contractor's performance on the measures it is required to report.

(2) The outcomes and trended results of each Performance Improvement Project.

(3) The results of any efforts to support community integration for LTSS members.

c. Contractor's QAPI program must include strategies and activities as required under the State Quality Strategy, 42 CFR § 438.330, and other federal obligations to improve certain elements of the services provided by Contractor to Members, as well as information about processes and procedures related to the QAPI.

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.

[47] This existing OAR will be updated effective 1/1/2026.

(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 and 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 and Scoring Committee may specify scoring on a tiered basis or on the basis of ability to report data. The Metrics and 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 and 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 and Scoring Committee approves publication by a later date due to unforeseen circumstances that would impact a specific measure or measures.

(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 and 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 the last Friday 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 Friday of March of the Distribution Year will not be included in the incentive Measure calculation. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

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. 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 and 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 21 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 and 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 annually to OHA through the Ex. L reporting form designated for this purpose. Such arrangements and amounts paid shall be broken out by quarter in the annual report and shall include the name of each recipient organization, a description of the expenditure, and other details required by OHA. Contractor shall submit this annual report to OHA in conjunction with its 4th Quarter Ex. L reports. The reporting cycle for this report is as follows, with reference to Contract Years for purposes of illustration: The annual report due in Contract Year seven (2026) is for Quality Pool Measurement Year 2024 paid in Distribution Year 2025.

6. Performance Improvement Projects

a. In accordance with the State Quality Strategy and 42 CFR § 438.330(d), Contractor shall ongoing create and implement a program of Performance Improvement Projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to 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 for at least four (4) of the eight (8) focus areas listed in Sub.Paras. (1)-(8) below as follows: (i) One must be the Statewide PIP focus area in Sub.Para. (4); (ii) one must be the PIP required by the OHP SUD 1115 Demonstration Waiver approved by CMS which addresses one of the remaining seven focus areas; and (iii) at least two other focus areas selected by Contractor that satisfy the requirements set forth in 42 CFR § 438.358 and 438.330(a)(2).

(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.

(8) Social Determinants of Health and Equity.

c. CMS, in consultation with OHA and other invested parties 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 PIP 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 Quality Strategy, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract. Contractor shall submit its proposed PIP using the PIP Notification Form located on the CCO Contract Forms Website.

(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 submit to OHA, via Administrative Notice, status reports for each of its four (4) PIPs. Status reports for the two (2) PIPs selected by Contractor are due semi-annually on January 31 and July 31 of each Contract Year. Status reports for the two (2) Statewide PIPs are due annually on January 31 of each Contract Year. Contractor must use OHA's PIP progress Report template located on the CCO Contract Forms Website for all such status reports.

(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.

f. In addition to the above annual status reports, Contractor shall submit to OHA, via Administrative Notice, information about the two (2) statewide PIPs as required for EQR validation purposes. Contractor shall submit such information by July 31 of each Contract Year, using the approved EQRO vendor protocol validation submission template provided by OHA.

7. Additional Health System Transformation Obligations

a. Contractor shall, in accordance with OAR 410-141-3525, convene a Quality Improvement Committee to oversee its quality assurance performance improvement efforts. Contractor's Quality Improvement Committee shall oversee and be responsible for Contractor's Monitoring of its QAPI program which shall include, without limitation review and approval of its annual QAPI evaluation. 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 § 438.364(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 30 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.

9. Excluded Populations

None of the provisions included in this Ex. B, Part 10 shall apply to HOP Members covered by this Contract.

[Remainder of page intentionally left blank]

Exhibit C – Consideration

1. Payment Types and Rates

a. In consideration of all the Work to be performed under this Contract, OHA will pay Contractor a monthly CCO Payment for each Member enrolled under the Contract according to OHA records. The monthly CCO Payment Rate authorized for each Member is that amount indicated in Exhibit C-Attachment 1 (CCO Payment 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 factors such as expected cost of care or health status and may reflect one or more Risk Corridors in accordance with Sec. 6 below of this Ex. C.

c. 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).

d. Pursuant to 42 CFR § 438.6(c), CMS governs how states may direct managed care plans' expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. OHA refers to these payments as Qualified Directed Payments (QDPs). OHA shall utilize two types of QDPs in this Contract, the details of which are specified in Sub.Paras. (1) and (2) below. QDPs are based on OHA's authority under its CMS approved 1115 waiver. As required under 42 CFR 438.6(c), all QDPs are subject to the terms, conditions, and population limitations approved by CMS and will become effective under this Contract as of January 1, 2026, upon (and regardless of the date of) CMS approval.[48]

(1) *Separate Payment Term QDPs:* OHA will issue these payments to Contractor after eligible utilization information is submitted to OHA as Encounter Data. OHA does not issue any such payments for EHB-eligible services provided to HOP Members who are covered under this Contract. These Payments are separate from the CCO Payment Rates paid by OHA to Contractor ("Separate Payment Term QDPs"). The Separate Payment Term QDPs in effect as of the effective date of this Contract are specified in Sub-Sub.Paras. (a), (b), and (d) below. Payment of such QDPs made by OHA to Contractor under Sub-Sub.Paras (a), (b), and (d) below of this Sub.Para. (1) include amounts to be retained by Contractor to cover the cost of managed care taxes. The conditions that Providers must meet in order for Contractor to pay out the Separate Payment Term QDPs identified in Sub-Sub. Paras. (a) and (b) are set forth in the OARs cited therein. The process that Contractor must follow in paying out the Separate Payment Term QDPs identified in Sub-Sub.Paras. (a) and (b) is set forth in Sub-Sub.Para. (c) below of this Sub.Para. (1). The conditions and processes that must be followed for paying out the Separate Payment Term QDP to Providers under Sub-Sub.Para. (d) are specified therein. In the event the OARs are amended to include new Separate Payment Term QDPs, such QDPs may be implemented as applicable under this Contract.

(a) QDPs to be paid by Contractor to Hospitals are subject to OAR 410-125-0230.

[48] Federal regulations require this Contract to reflect the final directed payments approved by CMS. Depending on the timing of CMS approval, OHA may need to ~~either update the Contract prior to sending it to Contractor for signature in November 2026 or~~ amend the Contract at a later date.

(b) QDPs to be paid by Contractor to Ground Emergency Medical Transportation (GEMT) Providers that are governmental units are subject to OAR 410-136-3371 and to private GEMT providers are subject to OAR 410-136-3374.

(c) Providers that have met the conditions of the Separate Payment Term QDPs identified in Sub-Sub.Paras. (a) and (b) above of this Sub.Para. (1) and the amount of the QDP that Contractor must pay to each such Provider will be identified in the periodic reports Contractor receives from OHA. Contractor shall pay the identified Provider the identified QDP amount by submitting electronic payment to an account established by each Provider within five (5) Business Days after receipt of each applicable periodic report. If an error is identified in the periodic report, Contractor shall make the payment based on the original amount provided in the report. OHA will identify separately the correction in a following report and adjust the total payment amount to account for the error.

(d) *QDPs to be paid by Contractor to Hospitals under the Rural Hospital Maternity Directed Payment Program:* To be eligible for payment under the Rural Hospital Maternity QDP, a Hospital must be a Rural Type A/B Hospital and provide maternity services that meet the requirements specified in a separate agreement between OHA and the Hospital ("Separate Maternity Program Agreement") and satisfy all other requirements of the Separate Maternity Program Agreement.

i. OHA will provide timely Administrative Notice to Contractor of the uniform increase payment amounts – which shall be payable for both inpatient and outpatient encounters – for the Rural Hospital Maternity QDP after OHA receives notice from CMS that such amounts have been approved.

ii. OHA will calculate Contractor's payment to each Hospital using the CMS approved amounts, limited to one encounter per Member per day per Hospital based on inpatient and outpatient encounters on dates of service in 2026.

iii. OHA will provide Contractor with the funds designated for the Rural Hospital Maternity QDP on a weekly basis via Electronic Funds Transfer. OHA will provide Contractor with a monthly report to assist Contractor in distributing the funds to the appropriate Hospital. The report shall be distributed to Contractor and each Hospital.

A. The provision of this report by OHA to Contractor will serve as Administrative Notice that each Hospital named in the report has met the obligations under its Separate Maternity Program Agreement necessary for receiving the Rural Hospital Maternity QDP.

iv. Within five (5) Business Days after receipt of the Rural Hospital Maternity QDP monthly report, Contractor shall submit an electronic payment to an account established by the applicable Hospital for the amount indicated in the report.

A. Adjustments shall be processed weekly through the Medicaid payment system and included in the monthly report.

B. If an error is identified in the monthly report, Contractor shall make the payment based on the original amount provided in the report. OHA shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.

(2) *QDPs within CCO Payment Rates:* The QDPs within CCO Payment Rates described in this Sub.Para. (2) are reflected in the CCO Payment Rates contained in the Actuarial Report identified in Sec. 7 of this Ex. C. The QDPs within CCO Payment Rates shall become effective under this Contract upon (and regardless of the date of) approval by CMS. The QDPs within CCO Payment Rates in Sub-Sub.Paras. (a), (b), (d), and (e) below of this Sub.Para. (2) are for the purpose of increasing Behavioral Health (BH) Provider payment rates as contemplated by Enrolled Oregon House Bill 5202 (2022). OHA will provide a guidance document ("QDP Guidance Document") to assist Contractor with complying with the QDP requirements in this Sub.Para. (2). Contractor may, but is not required to, pay an amount similar to the QDPs within CCO Payment Rates described in this Sub.Para. (2) to EHB-eligible services provided to HOP Members who are covered by this Contract.

(a) *Increased Payments for Team-Based High Acuity Medicaid Providers:* Payment rate increases are achieved through a uniform increase to payments based on whether a BH Participating Provider is part of a team-based practice that serves individuals with high acuity mental health conditions enrolled in Oregon's Medicaid and Children's Health Insurance Program (CHIP) programs (collectively referred to as "Medicaid"). Notwithstanding the foregoing, Mobile Crisis Services and Mobile Crisis Intervention Services are not eligible to receive the payment rate increase described in this Sub-Sub.Para. (a); instead, they must be paid in accordance with Sub-Sub.Para. (e) below of this Sub.Para. (2).

i. For purposes of this QDP, a BH Participating Provider will be deemed to be a Team-Based High Acuity Medicaid Provider ("TBHA Medicaid Provider") provided it meets one of the following criteria:

A. A Community Mental Health Program providing one or more of the following services or programs: Assertive Community Treatment (ACT), Early Assessment and Support Alliance, and Intensive In-Home Behavioral Health Treatment; or

B. A Provider that meets all three of the following requirements:

(I) Has a Certificate of Approval from OHA; and

(II) Derives at least fifty percent (50%) of its annual BH revenue from services provided to individuals enrolled in Oregon's Medicaid program; and

(III) Offers integrated, team-based care consisting of any combination of, as clinically indicated, the following: On-staff or need-based contracted psychiatric provider; integrated peer support; case management services; and individual, family, group, and community-based services~~, as clinically indicated~~.

ii. Subject to a BH Participating Provider meeting the criteria for a TBHA Medicaid Provider, Contractor shall, for Contract Year seven (2026), pay a QDP to such Providers in accordance with the following:

A. An amount that is at least ten percent (10%) more than the State Plan BH payment rates in effect on January 1, 2026.

B. Contractor shall not pay TBHA Medicaid Providers the QDP rate hereunder unless such Provider has first confirmed in writing to Contractor that it meets one of the TBHA Medicaid Provider criteria in Sub-Sub.Para. (a) i. (A) or (B) of above of this Sub.Para. (2). The required method for such confirmation is the Provider's submission to Contractor of the BH Provider QDP Attestation, which is provided on the CCO Contract Forms Website. Upon acceptance of such confirmation, Contractor shall implement the TBHA Medicaid Provider rate as of either (i) the effective date of this Contract if Contractor accepted the confirmation prior to its effective date or (ii) the first day of the calendar quarter in the Contract Year in which the Provider provided the confirmation to Contractor.

(b) *Minimum Fee Schedule for Culturally and Linguistically Specific Services (CLSS) Payment Increase for BH Participating Providers:* This QDP provides a uniform payment increase (subject to, however, the BH Participating Provider's "Rural" or "Non-rural" classification) for qualified BH Participating Providers, consistent with the State Plan Amendment, that provide the following services: (i) Assertive Community Treatment (ACT); (ii) Supported Employment Services (SE); (iii) Applied Behavior Analysis (ABA); (iv) Wraparound; (v) Outpatient Mental Health Treatment and Services (OP MH); (vi) Outpatient Substance Use Disorder Treatment and Services (OP SUD); and (vii) Residential Substance Use Disorder Treatment and Services (Residential SUD) which meet CLSS eligibility requirements where the payment increase varies based on whether the BH Participating Provider is regarded as Non-rural or Rural. The amount of each payment increase is specified in i. and ii. below of this Sub-Sub.Para. (b). The payment increase required to be made pursuant to this QDP must be in addition to any payment rate increase that may be paid to a BH Participating Provider as described in Sub-Sub.Para. (a) above of this Sub.Para. (2).

i. For Non-rural BH Participating Providers, the payment increase must be equal to twenty-two percent (22%) of the applicable State Plan BH payment rate in effect on January 1, 2026.

ii. For Rural BH Participating Providers, the payment increase must be equal to twenty-seven percent (27%) of the applicable State Plan BH payment rate in effect on January 1, 2026.

(c) *Minimum Fee Schedule for Culturally and Linguistically Specific Services (CLSS) Payment Increase for Traditional Health Workers (THWs):* The QDP provides a uniform payment increase (subject to, however, the Participating Provider's Non-rural or Rural classification) as defined in guidance for services performed by THW Participating Providers, consistent with the State Plan Amendment, that

meet CLSS eligibility requirements where the payment increase varies based on whether the Provider is regarded as Non-rural or Rural.

i. For Non-rural THW Participating Providers, the payment increase must be equal to twenty-two percent (22%) of the applicable State Plan payment rate in effect on January 1, 2026.

ii. For Rural THW Participating Providers, the payment increase must be equal to twenty-seven percent (27%) of the applicable State Plan payment rate in effect on January 1, 2026.

(d) *Minimum Fee Schedule for Co-Occurring Disorder (COD) Services Payment Increase:* This QDP provides a uniform payment increase for BH Participating Providers approved by OHA for integrated treatment of Co-Occurring Disorders (COD) pursuant to OAR 309-019-0145 and consistent with the State Plan Amendment. The amount of each payment increase covered by this QDP is specified in i. through iii. below of this Sub-Sub.Para. (d). The payment increase provided under this QDP must be in addition to any payment rate increase that may be paid to a BH Participating Provider as described in Sub-Sub.Para. (a) above of this Sub.Para. (2).

i. For BH Participating Providers of non-residential services who are Qualified Mental Health Associates, Peers, or SUD Treatment Staff as defined in OAR 309-019-0105, the payment increase must be equal to ten percent (10%) of the applicable State Plan BH payment rate in effect on January 1, 2026.

ii. For BH Participating Providers of non-residential services who are Qualified Mental Health Professionals, Licensed Health Care Professionals, or Mental Health Interns as defined in OAR 309-019-0105, the payment increase must be equal to twenty percent (20%) of the applicable State Plan BH payment rate in effect on January 1, 2026.

iii. For BH Participating Providers of Residential SUD, the payment increase must be equal to fifteen percent (15%) of the applicable State Plan BH payment rate in effect on January 1, 2026.

(e) *Minimum Fee Schedule for Providers of Residential SUD, ABA, Mobile Crisis Services, Mobile Crisis Intervention Services, and Wraparound:* Contractor shall pay all such BH Providers, whether Participating or Non-Participating, no less than the applicable State Plan BH payment rate in effect on January 1, 2026.

(f) *Alternative Payment Methodologies (APMs):* Contractor may pay BH Participating Providers utilizing APMs. Contractor must demonstrate to OHA that the overall payments to such Providers through APMs are consistent with the increases resulting from the BH QDPs in Sub-Sub.Paras. (a), (b), (d), and (e) above of this Sub.Para. (2). Such demonstration shall occur through the combination of Contractor's financial reporting described in Ex. L and submission of the Attestation described in Sub-Sub.Para. (h) below of this Sub.Para. (2) in which Contractor shall provide a detailed description of how it adjusted its APMs to comply with the BH QDPs.

(g) Contractor shall provide OHA with information relating to QDPs as specified in the QDP Guidance Document. Further, OHA will modify certain existing Reports

to collect information relating to QDPs. OHA will update the QDP Guidance Documents or reporting templates, or both, associated with the affected Reports.

(h) By March 31 of each Contract Year, Contractor shall provide to OHA, via Administrative Notice, an Attestation of compliance with the requirements of Sub-Sub.Paras. (a-e) above of this Sub.Para. (2). Contractor shall make the required Attestation of compliance using the Attestation form provided by OHA on the CCO Contract Forms Website. Additionally, by September 30 of each Contract Year, Contractor shall provide to OHA, via Administrative Notice, an updated Attestation of compliance for Providers whose contracts are new or have been modified for any reason relating to payment rates since the initial Attestation submitted by March 31 of the same Contract Year. If OHA determines that Contractor's Attestation misrepresents its compliance with the requirements of Sub-Sub.Paras. (a-e) above of this Sub.Para. (2), then Contractor shall be in breach of this Contract and OHA will have the right to impose one or more Sanctions, including civil money penalties, consistent with Ex. B, Part 9, Sec. 3.

(i) Contractor shall maintain a public webpage that informs Providers about the qualification requirements for all QDPs described in this Sub.Para. (2). Such public webpage must also prominently display the contact information for a representative of Contractor who has knowledge sufficient to assist Providers with questions about QDP requirements. OHA will post Contractor's URL on an OHA public facing webpage that includes information about QDPs targeted to Providers. If Contractor changes the URL for its QDP webpage, Contractor shall provide the new URL to OHA, via Administrative Notice, within ten (10) days of the date of change.

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 Ex. 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. 21, 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. 13, Ex. 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 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 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 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 (2) 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 Sub.Para. (5) or Sub.Para. (5), Sub-Sub.Para. (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 Sub.Para. (5) or Sub.Para. (5), Sub-Sub.Para. (a) above is 1% or greater of the total OHP rates, the CCO Payment Rates will be amended pursuant to Sec. 21, 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, Para. d, Sub.Paras. (1) through (5) of this Sec. 3, Ex. C do not apply to reductions made by the Legislative Assembly in a legislatively adopted or approved budget.

e. With respect to the CCO Payment Rates in Exhibit C-Attachment 1, CMS advised OHA in June 2023 through a State Plan Amendment that OHA may claim CHIP administrative funds as federal match for postpartum HOP Members' EHB under this Medicaid Contract.

(1) OHA will apply the "HOP MAGI Postpartum 0-365 Days (HOP PP)" rates set forth in Exhibit C-Attachment 1 as of the 2026 A&R Effective Date.

(2) In the event CHIP administrative funds have been exhausted or other factors prevent OHA from continuing to issue payments under the HOP PP rates, the HOP PP rates under this Contract will cease to have effect for postpartum HOP Members, and OHA will instead pay Contractor for all postpartum HOP Members according to the "HOP Postpartum Contingent" rates set forth in Exhibit C-Attachment 1.

(3) Due to regulatory and systems limitations, OHA may not be aware of either the inability to claim CHIP administrative funds or the other factors that may prevent OHA from continuing to pay the HOP PP rates until after the effective date of such unavailability. Consequently, the change to the rates under which Contractor is paid for postpartum HOP Members may require OHA to make coordinated retroactive adjustments in order to recoup previously issued payments and instead issue HOP Postpartum Contingent payments (collectively, "Reprocessing"). Therefore, OHA will notify Contractor no later than ninety (90) days after the effective date of the retroactive adjustment and the reason therefor. OHA will also provide Contractor with at least thirty days (30) prior written notice of any Reprocessing and the enactment of prospective payments. OHA may provide the two aforementioned notices to Contractor concurrently or consecutively, as determined by OHA based on the circumstances. Notice(s) provided hereunder shall be made by OHA via Administrative Notice.

f. This Sec. 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 Para. a. of this Sec. 4 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 eighteen (18) months from the affected Enrollment period.

c. OHA will make retroactive CCO Payments to Contractor for any Member(s) erroneously omitted from the Enrollment transaction files. Such payments will be made to Contractor once OHA 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, Sec. 6, Para. 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, Sec. 6, Para. 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 Sub.Para (4) of this Para. g, Sec. 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 Sec. 7, Ex. D of this Contract.

6. Risk Corridors

Contractor shall comply with the requirements for administration of the Risk Corridors established in this Sec. 6. The 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. Handicapping Malocclusions Risk Corridor Definitions.

(1) "Handicapping Malocclusions Risk Corridor Period" means January 1, 2026, through December 31, 2026.

(2) "Handicapping Malocclusions Expense" means the costs for priced and repriced encounters for Handicapping Malocclusions treatment rendered in compliance with OAR 410-123-1260 and any related guidance issued by OHA. Such OHA guidance will identify the procedure codes included in the Handicapping Malocclusions Expense. (Excluded from Handicapping Malocclusions Expense are encounters for procedure code D8660 [orthodontic evaluation] and for select low-volume procedure codes for related services.) In determining Handicapping Malocclusions Expense, priced encounters will be limited to one hundred twenty percent (120%) of State Plan payment rates. OHA will reprice Encounter Data claims that have no paid amounts using methods OHA publishes when it provides the Handicapping Malocclusions Settlement Calculation Form to Contractor.

(3) "Handicapping Malocclusions Revenue" means the amount paid to Contractor by OHA for Handicapping Malocclusions services in Capitation Payments for dates of service during the Handicapping Malocclusions Risk Corridor Period, excluding the administrative component of the rates and any managed care tax.

(4) "Handicapping Malocclusions Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the Handicapping Malocclusions settlement covering the Handicapping Malocclusions Risk Corridor Period.

b. Handicapping Malocclusions Settlements.

(1) Completion of Data Submissions. No later than April 30, 2027, Contractor shall submit to OHA Encounter Data and any supporting information for the Handicapping Malocclusions Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

(2) Contractor shall also submit to OHA for Members receiving screening or treatment for Handicapping Malocclusions for dates of service during the Handicapping Malocclusions Risk Corridor Period the following information:

(a) In a form and at a time specified by OHA, an attestation that all treatments claimed under the Handicapping Malocclusions Risk Corridor comply with OAR 410-123-1260 and any related guidance issued by OHA, including but not limited to Prior Authorization protocol as specified in the OHA-approved coverage criteria for FFS Members; and

(b) If requested by OHA, details of the care management for each Member receiving treatment for Handicapping Malocclusions.

c. Operation of the Handicapping Malocclusions Risk Corridor.

(1) Following receipt of data submissions, OHA shall provide the Handicapping Malocclusions Settlement Calculation Form to Contractor. The Handicapping Malocclusions Settlement Calculation Form will display Handicapping Malocclusions Revenues and Expenses and supporting data and reflect the settlement calculation described below.

(2) Contractor shall review and reply to the Handicapping Malocclusions Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include any additional OHA-requested information needed to support the settlement calculation.

(3) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of Handicapping Malocclusions Expense, and to indicate the amount of the Handicapping Malocclusions Risk Corridor Payment.

(4) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

d. Handicapping Malocclusions Risk Corridor Payments.

(1) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor or Contractor owes a payment to OHA. The following payments will be made after the Handicapping Malocclusions Revenue and Handicapping Malocclusions Expenses have been determined for the Handicapping Malocclusions Risk Corridor Period.

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

(a) When Contractor's Handicapping Malocclusions Expenses for the Handicapping Malocclusions Risk Corridor Period are between one hundred percent (100%) and one hundred twenty percent (120%) of the Handicapping Malocclusions Revenue, OHA will pay Contractor an amount equal to seventy-five percent (75%) of the Handicapping Malocclusions Expenses between one hundred percent (100%) and one hundred twenty percent (120%) of the Handicapping Malocclusions Revenue; or

(b) When Contractor's Handicapping Malocclusions Expenses for the Handicapping Malocclusions Risk Corridor Period are equal to or greater than one hundred twenty percent (120%) of the Handicapping Malocclusions Revenue, OHA will pay Contractor an amount equal to one hundred percent (100%) of Handicapping Malocclusions Expenses in excess of one hundred twenty percent (120%) of the Handicapping Malocclusions Revenue, and seventy-five percent (75%) of Handicapping Malocclusions Expenses between one hundred percent (100%) and one hundred twenty percent (120%) of Handicapping Malocclusions Revenue.

(3) Contractor will owe a payment to OHA in the following amounts under the following circumstances:

(a) When Contractor's Handicapping Malocclusions Expenses for the Handicapping Malocclusions Risk Corridor Period are between eighty percent (80%) and one hundred percent (100%) of the Handicapping Malocclusions Revenue, Contractor shall owe OHA an amount equal to seventy-five percent (75%) of the excess between one hundred percent (100%) of the Handicapping Malocclusions Revenue and the Handicapping Malocclusions Expenses; or

(b) When Contractor's Handicapping Malocclusions Expenses for the Handicapping Malocclusions Risk Corridor Period are less than or equal to eighty percent (80%) of the Handicapping Malocclusions Revenue, Contractor shall owe OHA the combined total of (i) an amount equal to one hundred percent (100%) of the difference between Contractor's Handicapping Malocclusions Expenses and eighty percent (80%) of the Handicapping Malocclusions Revenue and (ii) an amount equal to seventy-five percent (75%) of Handicapping Malocclusions Revenue between eighty percent (80%) and one hundred percent (100%) of Handicapping Malocclusions Revenue.

(4) If Contractor owes a payment to OHA, then OHA will confer with Contractor about the method and timing of the payment or charge, which may include adjusting future payments to Contractor.

e. Indian Health Care Provider (IHCP) Risk Corridor Definitions.

(1) "IHCP Risk Corridor Period" means January 1, 2026, through December 31, 2026.

(2) "IHCP Expense" means the costs for priced encounters and for Alternative Payment Methodologies (APMs) for services delivered at IHCPs that are subject to encounter rate payment in compliance with any related guidance issued by OHA. Such IHCP payment guidance includes any documents published on the CCO Contract Forms Website and any technical documentation provided to Contractor via Administrative Notice. In determining IHCP Expenses, priced encounters and allowed amounts under APMs will be limited to the encounter rate times the number of qualified claims present in Contractor's Encounter Data.

(3) "IHCP Revenue" means the amount paid to Contractor by OHA for IHCP services in Capitation Payments for dates of service during the IHCP Risk Corridor Period, excluding the administrative component of the rates and any managed care tax.

(4) "IHCP Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the IHCP settlement covering the IHCP Risk Corridor Period.

f. IHCP Settlements: Data Submissions Necessary.

(1) No later than April 30, 2027, Contractor shall submit to OHA Encounter Data and any supporting information for the IHCP Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

g. IHCP Settlements: Operation of the IHCP Risk Corridor.

(1) Following receipt of data submissions, OHA shall provide the IHCP Settlement Calculation Form to Contractor. The IHCP Settlement Calculation Form will display IHCP Revenues and Expenses and supporting data and reflect the settlement calculation described below.

(2) Contractor shall review and reply to the IHCP Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include any additional OHA-requested information needed to support the settlement calculation.

(3) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of IHCP Expense, and to indicate the amount of the IHCP Risk Corridor Payment.

(4) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

h. IHCP Risk Corridor Payments.

(1) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor or Contractor owes a payment to OHA. The following payments will be made after the IHCP Revenue and IHCP Expenses have been determined for the IHCP Risk Corridor Period.

(2) Contractor will receive a payment from OHA in the following amount under the following circumstance:

(a) When Contractor's IHCP Expenses for the IHCP Risk Corridor Period exceed one hundred percent (100%) of the IHCP Revenue, OHA will pay Contractor an amount equal to eighty percent (80%) of the IHCP Expenses in excess of one hundred percent (100%) of the IHCP Revenue.

(3) Contractor will owe a payment to OHA in the following amount under the following circumstance:

(a) When Contractor's IHCP Expenses for the IHCP Risk Corridor Period are less than one hundred percent (100%) of the IHCP Revenue, Contractor shall owe OHA an amount equal to eighty percent (80%) of the difference between Contractor's IHCP Expenses and one hundred percent (100%) of the IHCP Revenue.

(4) If the payment calculated under Sub.Paras. (2) or (3) above is less than $30,000, no payment shall be required by Contractor or OHA.

(5) If Contractor owes a payment to OHA, then OHA will confer with Contractor about the method and timing of the payment or charge, which may include adjusting future payments to Contractor.

i. HRSN Administrative Expense Risk Corridor Definitions.

(1) "HRSN Administrative Expense Risk Corridor Period" means January 1, 2026, through December 31, 2026.

(2) "HRSN Actual Administrative Expense as a Percent of Direct Service Cost" ("Actual Admin Percent") means the HRSN administrative expense incurred by Contractor divided by the HRSN Services amount delivered to Contractor's Members. OHA will rely on the 2026 HRSN Administrative Settlement Template to determine Contractor's actual HRSN administrative expense and the HRSN Services amount delivered to Contractor's Members.

(3) "HRSN Target Administrative Expense as a Percent of Direct Service Cost" ("Target Admin Percent"), which is displayed in the table below, means the target percentage for HRSN Administrative Expense as a Percent of Direct Service Cost. HRSN Home Changes for Health-Related Supports, HRSN Housing-Related Supports, and HRSN Nutrition-Related Supports each has a separate Risk Corridor. The target percentage is different for each Risk Corridor and each Risk Corridor will be calculated separately. The target percentage also differs by CCO Tier within each Risk Corridor. Use of the term "CCO Tier" in this context is explained in the Actuarial Report titled "Oregon CY26 Rate Certification – CCO Rates" available at https://www.oregon.gov/oha/fod/pages/ohp-rates.aspx. The target percentage is based on the expected HRSN Services amounts in Contract Year seven (2026) and are net of any managed care tax. OHA, in its sole discretion, may increase the target percentage. This increase may occur for one or more or all CCOs and the increase may vary by CCO. In the settlement calculation, more digits of precision for the percents of direct service cost will be included than displayed in the table below. For purposes of the Target Admin Percent table below, OHA has determined Contractor is CCO Tier ~~[insert CCO-specific #].~~«M_2026_Tiers_for_MMLR_and_HRSN».

HRSN Service	CCO Tier 1	CCO Tier 2	CCO Tier 3
Home Changes for Health-Related Supports	43.7%	54.6%	98.3%
Housing-Related Supports	25.1%	30.9%	54.2%
Nutrition-Related Supports	24.8%	31.0%	55.8%

(4) "HRSN Administrative Expense Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the HRSN Administrative Expense settlement covering the HRSN Administrative Expense Risk Corridor Period.

j. HRSN Administrative Expense Settlements.

(1) Completion of Data Submissions. No later than April 30, 2027, Contractor shall submit to OHA Encounter Data and any supporting information for the HRSN Administrative Expense Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

k. Operation of the HRSN Administrative Expense Risk Corridor.

(1) Following receipt of data submissions, OHA shall provide the HRSN Administrative Expense Settlement Calculation Form to Contractor. The HRSN Administrative Expense Settlement Calculation Form will display the actual admin percent, target admin percent, and supporting data and reflect the settlement calculation described below.

(2) Contractor shall review and reply to the HRSN Administrative Expense Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include any additional OHA-requested information needed to support the settlement calculation.

(3) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of the

actual admin percent and to indicate the amount of the HRSN Administrative Expense Risk Corridor Payment.

(4) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

l. HRSN Administrative Expense Risk Corridor Payments.

(1) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor or Contractor owes a payment to OHA. The following payments will be made after the Actual Admin Percent and Target Admin Percent have been determined for the HRSN Administrative Expense Risk Corridor Period.

(2) The settlement calculation is as follows:

(a) The "Allowed Admin Percent" is equal to either (i) the Target Admin Percent if the Actual Admin Percent is less than the Target Admin Percent, or (ii) the Target Admin Percent plus twenty-five percent (25%) of the difference between the Actual Admin Percent and the Target Admin Percent.

(b) The Allowed Admin Percent will be multiplied by the HRSN Services amount delivered to Contractor's Members during the HRSN Administrative Expense Risk Corridor Period. The result is the maximum allowed administrative expense amount ("Max Allowed Admin Expense Amount").

(c) If the Max Allowed Admin Expense Amount is greater than the HRSN administrative expense payments OHA already made to Contractor incurred during the HRSN Administrative Expense Risk Corridor Period, Contractor will receive a payment from OHA for the difference in the amounts.

(d) If the Max Allowed Admin Expense Amount is less than the HRSN administrative expense payments OHA already made to Contractor incurred during the HRSN Administrative Expense Risk Corridor Period, Contractor will owe a payment to OHA for the difference in the amounts.

(e) If Contractor owes a payment to OHA, then OHA will confer with Contractor about the method and timing of the payment or charge, which may include adjusting future payments to Contractor.

m. Home Changes for Health Risk Corridor Definitions.

(1) "Home Changes for Health Risk Corridor Period" means January 1, 2026, through December 31, 2026.

(2) "Home Changes for Health Expense" means the cost for priced encounters for authorized Home Changes for Health services and devices. In determining Home Changes for Health Expense, priced encounters shall be limited to the lesser of (i) the amount paid for services and devices, as substantiated by Encounter Data submissions to OHA or (ii) the upper payment limit (UPL) associated with each applicable service or device specified in the HRSN Housing Fee Schedule. Priced encounters will be excluded from Home Changes for Health Expense if it is determined that an encounter is a duplicative service

as described in the HRSN Guidance Document (see HRSN Services Utilization Control table).

(3) "Home Changes for Health Revenue" means the amount paid to Contractor by OHA for Home Changes for Health services and devices in Capitation Payments for dates of service during the Home Changes for Health Risk Corridor Period, excluding the administrative component of the rates and any managed care tax.

(4) "Home Changes for Health Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the Home Changes for Health settlement covering the Home Changes for Health Risk Corridor Period.

n. Home Changes for Health Settlements: Data Submissions Necessary.

(1) No later than April 30, 2027, Contractor shall submit to OHA Encounter Data and any supporting information for the Home Changes for Health Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

o. Home Changes for Health Settlements: Operation of the Home Changes for Health Risk Corridor.

(1) Following receipt of data submissions, OHA shall provide the Home Changes for Health Settlement Calculation Form to Contractor. The Home Changes for Health Settlement Calculation Form will display Home Changes for Health Revenues and Expenses and supporting data and reflect the settlement calculation described below.

(2) Contractor shall review and reply to the Home Changes for Health Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include any additional OHA-requested information needed to support the settlement calculation.

(3) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of Home Changes for Health Expense, and to indicate the amount of the Home Changes for Health Risk Corridor Payment.

(4) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

p. Home Changes for Health Risk Corridor Payments.

(1) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor. Contractor will not owe payments to OHA as a result of this settlement. The following payments will be made after the Home Changes for Health Revenue and Home Changes for Health Expenses have been determined for the HRSN Home Changes for Health Risk Corridor Period.

(2) Contractor will receive a payment from OHA in the following amount under the following circumstance:

(a) When Contractor's Home Changes for Health Expenses for the Home Changes for Health Risk Corridor Period are between one hundred percent (100%) and one

hundred three percent (103%) of the Home Changes for Health Revenue, OHA will pay Contractor an amount equal to fifty percent (50%) of the Home Changes for Health Expenses between one hundred percent (100%) and one hundred three percent (103%) of the Home Changes for Health Revenue; or

(b) When Contractor's Home Changes for Health Expenses for the Home Changes for Health Risk Corridor Period are equal to or greater than one hundred three percent (103%) of the Home Changes for Health Revenue, OHA will pay Contractor an amount equal to one hundred percent (100%) of HRSN Home Changes for Health Expenses in excess of one hundred three percent (103%) of the Home Changes for Health Revenue, and fifty percent (50%) of the Home Changes for Health Expenses between one hundred percent (100%) and one hundred three percent (103%) of the Home Changes for Health Revenue.

q. Nothing in Paragraphs a. through p. above of this Sec. 6 shall apply to any HOP Members covered by this Contract.

r. Risk Corridor Definitions – HOP Members' EHB-eligible services.

(1) "EHB Risk Corridor Period" means January 1, 2026, through December 31, 2026.

(2) "EHB Expense" means priced encounters offset by reinsurance recoveries and drug rebates, along with other OHA-approved costs or adjustments reflected in Contractor's completed EHB Settlement Calculation Form, for HOP Members' EHB-eligible Covered Services for dates of service during the EHB Risk Corridor Period. For purposes of calculating EHB Expense, Contractor may not claim payment to any Provider for a HOP Member's EHB-eligible Covered Service provided under this Contract in an amount greater than that which the same Provider would be paid by Contractor for the same service if provided to a non-HOP Member under this Contract.

(3) "EHB Revenue" means the amount paid to Contractor by OHA for HOP Members covered under this Contract in Capitation Payments and case rate payments for dates of service during the EHB Risk Corridor Period, excluding the administrative component of the rates and any managed care tax.

(4) "EHB Settlement Calculation Form" means the form provided to Contractor by OHA for calculating the EHB settlement covering the EHB Risk Corridor Period.

s. Operation of the Risk Corridor for Covered Services rendered during the EHB Risk Corridor Period.

(1) EHB Settlements

(a) No later than April 30, 2027, Contractor shall submit Encounter Data to OHA for HOP Members' EHB-eligible Covered Services for dates of service during the EHB Risk Corridor Period. Contractor is responsible for ensuring that encounter claims data are received and successfully processed by OHA prior to the submission deadline.

(b) Following receipt of Encounter Data, OHA shall provide the EHB Settlement Calculation Form to Contractor.

i. In preparing the EHB Settlement Calculation Form, OHA will reprice Encounter Data claims that have no paid amounts using methods OHA

publishes when it provides the EHB Settlement Calculation Form to Contractor.

ii. OHA will use enrollment data for HOP Members covered under this Contract multiplied by their capitation rates for each Category of Aid (COA) and their case rates to calculate the EHB Revenue.

(c) Contractor shall review and reply to the EHB Settlement Calculation Form provided by OHA within forty-five (45) days of receipt. Contractor's reply shall include OHA-requested cost information such as incurred but not reported costs, and other Member service expenses.

(d) OHA will review Contractor's response to the settlement calculation within forty-five (45) days of the due date for Contractor's response. The outcome of OHA's review will be to accept, modify, or request further information on Contractor's calculation of EHB Expense, and to indicate the amount of the EHB Risk Corridor Payment.

(e) If Contractor does not agree with OHA's settlement calculation, Contractor may, by notice delivered by email to OHA's Contract Administrator within ten (10) Business Days of OHA's delivery to Contractor of OHA's settlement calculation, seek Administrative Review of Contractor's settlement calculation.

(2) EHB Risk Corridor Payments

(a) The outcome of the settlement calculation process will be used to determine whether OHA owes a payment to Contractor or Contractor owes a payment to OHA. The following payments will be made after the EHB Revenue and EHB Expenses have been determined for the EHB Risk Corridor Period.

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

i. When Contractor's EHB Expenses for the EHB Risk Corridor Period are between one hundred percent (100%) and one hundred ten percent (110%) of the EHB Revenue, OHA will pay Contractor an amount equal to fifty percent (50%) of EHB Expenses between one hundred percent (100%) and one hundred ten percent (110%) of EHB Revenue; or

ii. When Contractor's EHB Expenses for the EHB Risk Corridor Period are equal to or greater than one hundred ten percent (110%) of the EHB Revenue, OHA will pay Contractor an amount equal to one hundred percent (100%) of EHB Expenses in excess of one hundred ten percent (110%) of EHB Revenue and fifty percent (50%) of EHB Expenses between one hundred percent (100%) and one hundred ten percent (110%) of EHB Revenue.

(c) Contractor will owe a payment to OHA in the following amounts under the following circumstances:

i. When Contractor's EHB Expenses for the EHB Risk Corridor Period are between ninety percent (90%) and one hundred percent (100%) of EHB Revenue, Contractor shall owe OHA an amount equal to fifty percent (50%) of the excess between one hundred percent (100%) of EHB Revenue and EHB Expenses; or

ii. When Contractor's EHB Expenses for the EHB Risk Corridor Period are less than or equal to ninety percent (90%) of EHB Revenue, Contractor shall owe OHA the combined total of (i) an amount equal to one hundred percent (100%) of the difference between Contractor's EHB Expenses and ninety percent (90%) of EHB Revenue and (ii) an amount equal to fifty percent (50%) of EHB Revenue between ninety percent (90%) and one hundred percent (100%) of EHB Revenue.

(d) If Contractor owes a payment to OHA, then OHA will confer with Contractor about the method and timing of the payment or charge, which may include adjusting future payments to Contractor.

t. Potential Behavioral Health Risk Corridor.

(1) Prior to the 2026 A&R Effective Date, the Parties engaged in good faith discussions regarding the potential ~~implementation~~implementation of a Risk Corridor for Behavioral Health services, as described in the summary proposal provided by OHA to Contractor on September 4, 2025. The Parties acknowledge that any agreement on the implementation of such a Behavioral Health Risk Corridor requires a separate amendment to this Contract. Accordingly, any mutual agreement to implement a Behavioral Health Risk Corridor is effective in accordance with such amendment. In no case will such a Behavioral Health Risk Corridor apply to any HOP Members covered by this Contract.

7. Global Payment Rate Methodology

a. In accordance with requirements under 42 CFR Part 438, Exhibit C-Attachment 1 contains the CCO Payment Rates to reimburse Contractor for providing Covered Services to its Members. A full description of the methodology used to calculate per capita costs may be found in the OHA documents "Oregon CY26 Rate Certification – CCO Rates" and "Healthier Oregon Program (HOP) 2026 Actuarial Certification." The Actuarial Reports are available at https://www.oregon.gov/oha/FOD/Pages/OHP-Rates.aspx. The Actuarial Reports are not part of this Contract, and except where specifically referred to herein, may not be used in the interpretation or construction of this Contract.

b. Capitation Rates paid to Contractor may include a component of Performance Based Reward (PBR) program in alignment with the State 1115 Waiver. The waiver specifies that OHA will fund Flexible Services through the Oregon Health Plan and establish financial incentives for successful Flexible Services spending. The purpose of the PBR program is to incentivize CCOs to pay for Flexible Services that will improve health and reduce medical cost. The PBR program pays a variable underwriting margin to CCOs based on their Flexible Services investments and success in controlling overall cost growth as well as an assessment of Quality Measures. The PBR formula contains limits to ensure that the impact on capitation rates remain within CMS guidance. Contractor's participation in the PBR program is voluntary, and the conditions of that participation will be communicated by OHA, via Administrative Notice, to Contractor in connection with Capitation Rates development. The amount of overall PBR funds available, specific formula parameters, and the resulting calculations are provided in the Actuarial Report referenced in Paragraph a. above of this Sec. 7.

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. 15.

9. Quality Pool

Contractor will be eligible for additional payments under the Quality Pool in accordance with Ex. B, Part 10.

10. Minimum Medical Loss Ratio

a. In accordance with 42 CFR § 438.8 Contractor shall maintain a Minimum Medical Loss Ratio (MMLR) at or above the MMLR Standard and shall submit, as set forth in Paras. g. and h. below of this Sec. 10, an annual, certified MMLR Rebate Report which validates its compliance with this requirement.

b. Contractor shall apply the following standards to the information used to calculate its Federal MLR and Oregon MLR:

(1) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(2) Expenditures that benefit multiple contracts or populations, or contracts other than this Contract, must be reported on pro rata basis.

(3) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(4) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(5) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

(6) Aggregate data for all Medicaid eligibility groups covered under this Contract, unless OHA requires separate reporting and a separate MLR calculation for specific populations in the MMLR Template and Instructions described in Paragraph g.

c. A Credibility Adjustment may be applied to Contractor's calculated MLR if the MLR reporting year is Partially Credible. A Credibility Adjustment may not be applied to Contractor's calculated MLR if the MLR reporting year experience is Fully Credible. If Contractor's experience is Non-credible, it is presumed to meet or exceed the MLR calculation standards.

(1) Any Credibility Adjustment is determined in the MMLR Template automatically based on member months information input by Contractor. The MMLR Template adds any Credibility Adjustment to the reported MLR calculation before calculating any remittances. Contractor is responsible for the accuracy and completeness of information input into the MMLR Template. OHA will ensure that the MMLR Template prompts Contractor to input the necessary information and correctly calculates Contractor's MLR based on the information input by Contractor.

d. Contractor shall require any third-party vendor performing claims processing functions to provide all underlying data associated with MLR reporting to Contractor within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by Contractor, whichever comes sooner, to calculate and validate the accuracy of MLR reporting.

e. If Contractor delegates any Work to be performed under this Contract to a Subcontractor(s) and Contractor's payment to the Subcontractor(s) is a risk-based or at-risk arrangement, then effective January 1, 2024, Contractor must require such Subcontractors to comply with the (i) MLR reporting requirement set forth in 42 CFR § 438.8(k) and (ii) MLR remittance requirement set forth in 42 CFR § 438.8(j), except that such MLR reports and remittances shall be submitted by the Subcontractor to Contractor, not to OHA as indicated in 42 CFR § 438.8. Contractor shall apply the Oregon MLR to the MLR calculation for such Subcontractors. OHA will provide additional information about CCO Subcontractor MLR reporting and remittance requirements in the MLR Guidance Document provided on the CCO Contract Forms Website.

(1) Contractor may, but is not required to, use the Subcontractor MLR reporting template provided by OHA on the CCO Contract Forms Website.

f. Contractor shall re-calculate the MLR and re-submit the MMLR Rebate Report within the timeframe specified by OHA if OHA makes a retroactive change to Contractor's Capitation Rates for the affected MLR reporting year and Contactor had previously submitted the MMLR Rebate Report for the affected MLR reporting year to OHA.

g. 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.

(1) Effective beginning with the Rebate Period for Contract Year five (2024), Contractor may, at its discretion, designate all or a portion of the Rebate as an MLR Community Rebate. The opportunity for such designation is provided as an alternative to collection of the Rebate as described in Para. k below of this Sec.10.

(2) Contractor shall communicate such designation to OHA at the conclusion of the Rebate review and, as applicable, appeal processes described in this Sec. 10 in accordance with the instructions in the Guidance Document located on the CCO Contract Forms Website.

(3) Contractor shall submit the plan for its use of the MLR Community Rebate in accordance with the Guidance Document, including use of any template provided by OHA. Contractor's plan is subject to review and approval by OHA. OHA will evaluate the plan in accordance with the requirements and timeline described the Guidance Document. Contractor shall not distribute any funds associated with the MLR Community Rebate prior to OHA approval of the plan.

h. Contractor shall submit its MMLR Rebate Report electronically utilizing the MMLR Template and following the MMLR 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.

i. All information reported on the MMLR Rebate Report must be for revenues and expenses under this Contract. 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.

j. 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 MMLR Template.

(1) If Contractor's MMLR Rebate Report submitted pursuant to Para. j above includes any distributions by Contractor of its earnings from the Quality Pool or Challenge Pool (or both), as those terms are used in Sec. 4 of Ex. B, Part 10, from the prior Contract Year,

then Contractor shall submit to OHA, via Administrative Notice, a supplemental MMLR Rebate Report by November 30 of the same year as the MMLR Rebate Report. This supplemental report requires Contractor to identify and attest to the accuracy of the specific amounts distributed by Contractor from its Quality Pool or Challenge Pool (or both) earnings from the prior Contract Year. (In this Sub.Para. (1), "prior Contract Year" is the same year as the Rebate Period and the Measurement Year, as each is defined in Ex. A. Both the initial MMLR Rebate Report and the supplemental MMLR Rebate Report are due in the same Distribution Year, as defined in Ex. A.)

k. 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 Administrative Notice of appeal from Contractor shall include written support for the appeal.

(3) Any appeal shall be conducted as an Administrative Review. The Administrative Review process will be conducted in the manner described in OAR 410-120-1580(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, verify the Rebate, if any, and notify Contractor within a reasonable period of time, via Administrative Notice, to Contractor's Contract Administrator.

l. 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.

[Remainder of page intentionally left blank]

Exhibit C – Consideration – Attachment 1 – CCO Payment Rates

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

For the period of January 1, 2026, through December 31, 2026, the following rates apply:

Rate Type
Plan Type CCOA – All Services
Plan Type CCOB – Physical Health and Behavioral Health Services
Plan Type CCOE – Behavioral Health Services Only
Plan Type CCOF – Dental Services Only
Plan Type CCOG – Behavioral Health and Dental 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.)

[Remainder of page intentionally left blank]

Exhibit D – Standard Terms and Conditions

1. Governing Law, Consent to Jurisdiction

This Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding collectively, the "Claim") 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 Sec. 1 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 (ADA) and Section 1557 of the ACA, 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 timely in alternate formats of communication, which may include Braille, large print, contrast, font change, audiotape, oral presentation, video, sign language video, and electronic format. OHA shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall include in the delivery of services all language access services and auxiliary aids necessary or as otherwise requested by a Member as required under the ADA and Section 1557 of the ACA, which includes but is not limited to, spoken language interpreters and sign language interpreters. 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 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. The warranties set forth in this Sec. 4 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

Sec. 5, Ex. D only, the "Document(s)"), Contractor shall, unless expressly provided otherwise in this Contract, follow the process set forth below in this Sec. 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. 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 SEC. 7. FOLLOWING EXHAUSTION OF THE ADMINISTRATIVE PROCEDURES SET FORTH BELOW IN PARAGRAPH b OF THIS SEC. 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 Ex. C, Sec. 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 NEGLIGENT, 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 SEC. 8 ARE NOT SUBJECT TO THE LIMITATION ON DAMAGES SET FORTH IN SEC. 12 BELOW OF THIS EX. 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 OHA's Contract Administrator; 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;

(8) Contractor fails to enter into an amendment described in Sec. 21, Para. b below of this Ex. D, as necessary for the amendment to go into effect on its proposed effective date; or

(9) Contractor is in breach of any other contract entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Non-Medicaid Contract or the OHP Bridge-BHP Contract, or another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract).

(10) 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.

(3) 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, Contractor's sole remedy shall be a claim for any unpaid amounts then due and owing from OHA to Contractor, as identified in Ex. 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 Sec. 12 below of this Ex. 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

(c) 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

(d) Notwithstanding any claim Contractor may have under Sec. 16, "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, Sub.Para. (4) 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. (4) 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; or

(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~~;~~ ~~or~~.

(3) OHA's Right to Terminate due to Termination or Non-Renewal of a Similar Contract.

(a) In the event OHA terminates a different contract that Contractor has entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Non-Medicaid Contract, the OHP Bridge-BHP Contract, or another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract), OHA shall have the right, but not the obligation, in its sole discretion, to terminate this Contract.

(b) In the event Contractor declines to Renew a different contract that Contractor has entered into with the State pursuant to which Contractor provides the same or substantively similar services as those provided under this Contract (e.g., the Non-Medicaid Contract, the OHP Bridge-BHP Contract), which covers the same Service Area as this Contract, OHA shall have the right, but not the obligation, in its sole discretion, to terminate this Contract. For the purpose of clarification, OHA will not have the right to terminate this Contract in the event Contractor declines to Renew another CCO contract entered into with OHA pursuant to which Contractor administers a Medical Assistance Program in a different Service Area than this Contract.

(4) Before Terminating this Contract under this Sec. 9, Para. e, Sub.~~Para~~Paras. (1~~)~~), (2), or ~~Sub.Para. (2~~(3) above of this Ex. 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.

(5) 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.

(6) 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 nine (2028), 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. (6) 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. (6) of this Ex. D and has the same effect as the failure to enter into a Renewal Contract.

(7) 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. (6) 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.

(8) OHA may waive compliance with the deadlines in Sub. Paras. (6) and (7) 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 2026 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 (7) of this Ex. D.

(9) 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. (7) and (8) 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.

(10) 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.

(11) 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. (7) above of this Ex. D (refusal to enter into an amended contract).

(12) 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 Sec. 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 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 Sec. 10 of this Ex. 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. 10-11 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 Flexible 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; an

(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 Ex. 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 Ex. F, attached hereto.

14. Transparency: Public Posting of Contractor Reports; Public Records Requests

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 Ex. 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.

e. Notwithstanding the public posting of redacted reports, all records in the possession of OHA are subject the Oregon Public Records Law (including ORS 192.311 to 192.478). In the event OHA receives any request under the Oregon Public Records Law for CCO reports or other CCO records in OHA's possession that have not been made publicly available under this Contract, OHA will notify Contractor within a reasonable period of time of the request such that Contractor may oppose the disclosure of any information included in the requested records that Contractor believes may be exempt under Oregon Public Records Laws, including ORS 192.311 to 192.478. In the event Contractor chooses to oppose a disclosure, Contractor shall be exclusively responsible for defending its position concerning the confidentiality of the requested information.

(1) In the event OHA receives a request for a public records request for CCO records that are not publicly posted, OHA will provide Contractor with Administrative Notice of such request. Within two (2) Business Days after the date that OHA provides Contractor with notice of the public records request, Contractor must advise OHA that Contractor intends

to oppose the disclosure or whether it has no objection to the disclosure. Notice hereunder by OHA to Contractor of the public records request and by Contractor to OHA of its intent to consent or oppose, shall be made via Administrative Notice. In the event Contractor fails to respond within two (2) Business Days after the date of OHA's Administrative Notice, Contractor shall be deemed to have consented to the disclosure, and OHA shall have no liability under this Contract at law or in equity for such disclosure.

(2) In the event OHA receives a public records request for CCO records that are publicly posted, OHA will advise the individual who has made the request that the records are publicly posted and available and may be downloaded without the assistance of OHA's public records office.

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, to evaluate the quality, appropriateness and timeliness of services, and to otherwise fulfill their obligations under this Contract and Applicable Law. 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 Sec. 15 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 Sec. 15 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. 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. 16 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 Para. a, Sec. 16 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.

17. 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.

18. 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 Ex. B, Part 8, Sec. 21. 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.

19. 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 Secs. 1, 2, 3, 4, 15, ~~16,~~ 18, 19, 24, and 30-32 of this Ex. ~~D.~~ D and also Ex. N if Subcontractor is required to have Access (as such term is defined in Sec. 2, Para. a of Ex. N) to OHA or State Data, Network and Information Systems, and Information Assets. OHA's consent to any Subcontract shall not relieve Contractor of any of its duties or obligations under this Contract.

20. 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.

21. 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 Sec. 6 of this Ex. 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 Ex. 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. 9, Para. a, Sub.Para. (8) 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.

22. 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.

23. 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.

24. 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 forth 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: Secs. 4 and 5

c. Exhibit B, Part 10: Sec. 3

d. Exhibit D: Secs. 1, 4 through 13, 15, 16, 18 through 29, and 31.

e. Exhibit E: Sec. 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 Sec. 12 of this Ex. D.

f. Exhibit N shall survive termination for the period of time that Contractor retains any Access (as such term is defined in Sec. 2~~.1~~, Para. a of Ex. N) to OHA or State Data, Network and Information Systems, and Information Assets.

g. 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 Ex. L;

(b) Audited annual financial statements as defined in Ex. 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 Ex. 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 Ex. B, Part 9.

25. 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. 25.

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 set forth below of this Para. a. In addition to the foregoing method of notice, on the same date as each such Legal Notice by Contractor to OHA, Contractor shall provide the same document(s) to OHA via Administrative Notice. Similarly, on the same date as each such Legal Notice by OHA to Contractor, OHA shall the provide the same document(s) to Contractor via Administrative Notice.

(1) **If to OHA:** To the physical address identified for OHA's Contract Administrator as set forth in Sec. 2 of the General Provisions of this Contract.

And with copy to (and notwithstanding the above requirements of this Para. 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 Ex. D, Sec. 25, Para. a.

(2) **If to Contractor**: To the physical address identified for Contractor's Contract Administrator as set forth in Sec. 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 Ex. D, Sec. 25, Para. 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 Ex. N and Exhibit C-Attachment 1.

(a) Or in such other form(s) or to such other destination(s) as OHA may identify in writing from time to time in accordance with this Ex. D, Sec. 25, Para. b.

(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 destination for a communication or deliverable and the destination 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 to the following email address: CCO.MCODeliverableReports@odhsoha.oregon.gov.

(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. 25, 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 Sec. 2 of the General Provisions of this Contract, except as provided for in Sub-Sub.Para. (a) below of this Para. b, Sec. 25, Ex. D. Or to such other Person(s) or address(es) as Contractor may identify in writing from time to time in accordance with this Ex. D, Sec. 25, Para. b.

(a) For matters reasonably within the scope of Ex. C or Ex. L or both, OHA will provide Administrative Notice by email to Contractor's Chief Executive Officer or Chief Financial Officer or both, instead of to Contractor's Contract Administrator.

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.

26. 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.

27. 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.

28. 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.

29. 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.

30. Equal Access

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

31. 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.

32. Mandatory Reporting of Abuse

a. Contractor shall immediately report any evidence of Child Abuse, neglect or threat of harm to ODHS 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 ODHS 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 Chapter 943, Division 45 and OAR Chapter 419, Divisions 210 and 240 (abuse investigations by the Office of Training, Investigations and Safety [OTIS]);

(2) ORS 430.735 through 430.765 (abuse reporting for adults with mental illness or developmental disabilities, including adults receiving services for a substance use disorder or a mental illness in a residential facility or a state hospital);

(3) ORS 124.005 to 124.040 (elderly persons and persons with disabilities abuse);

(4) ORS 441.650 to 441.680 (residents of long term care facilities); and

(5) ORS 418.257 to 418.259 (child in care of a Child-Caring Agency, residential facilities for children with intellectual/developmental disabilities and child foster homes).

c. Contractor shall report suspected Adult Abuse, neglect or financial exploitation as follows:

(1) Adults with developmental disabilities to the local community developmental disability program;

(2) Adults with mental illness to the local Community Mental Health Program;

(3) Patients of the Oregon State Hospital or residents of Substance Use Disorder treatment facilities to ODHS OTIS;

(4) Elder Abuse to the local ODHS Aging & People with Disabilities office or Area Agency for Aging;

(5) Nursing facility residents to the ODHS Nursing Facility Complaint Unit; or

(6) Or by calling 1-855-503-SAFE (7233). This toll-free number allows a report of abuse or neglect of any child or adult to be reported to ODHS.

[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 Affordable Care Act (ACA); (e) Executive Order 11246, as amended; (f) the Health Insurance Portability and Accountability Act of 1996, as amended; (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws; (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations; and (m) all federal laws requiring reporting of Member abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC. 14402.

2. Equal Employment Opportunity

If this Contract, including Amendments, 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 Sec. 3.

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 Ex. 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 Sec. 5 of this Ex. 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 Paras. e and f of this Sec. 5 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 14, and OAR Chapter 943, Division 14, 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, technical, and physical safeguards required by HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OAR Chapter 407, Division 14, and OAR Chapter 943, Division 14, and OHA Notice of Privacy Practices 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 Laws and the terms and conditions of this Contract. Incidents involving the privacy or security of Member Information must be immediately reported, but no later than one (1) Business Day after discovery, via Administrative Notice, to the Privacy Compliance Officer in OHA's Information Security and Privacy Office (ISPO) at DHS.PrivacyHelp@odhsoha.oregon.gov, with a follow-up telephone call to ISPO's Privacy Reporting Line at 503-945-5780.

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 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 Ex. B, Part 8, Sec. 3, "Access to Records."

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 Requirements

Contractor shall comply with all Applicable Laws 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 ODHS or OHA employee (or their relative or Member of their household), and no ODHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such ODHS or OHA employee participated personally and substantially in the procurement or administration of this Contract as a ODHS or OHA employee.

b. Contractor shall not offer, give, or promise to offer or give to any ODHS 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 199-005-0030.

c. Prior to the award of any replacement contract, Contractor shall not solicit or obtain, from any ODHS or OHA employee, and no ODHS or OHA employee may disclose, any proprietary or

source selection information regarding such procurement, except as expressly authorized by the Director of OHA or ODHS.

d. Contractor shall not retain a former ODHS 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 ODHS or OHA employee.

e. If a former ODHS 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 ODHS 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, ODHS, 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 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.

g. 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) the 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 Sec. 17 of this Ex. 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.

h. The provisions of this Sec. 17 of Ex. 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 Sec. 17:

(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 ODHS 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, Section 1557 of the ACA, 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 in accordance with 42 CFR Part 438, Subpart K detailed below and comply with the Mental Health Parity reporting requirements specified in Sec. 25 of Ex. M of this Contract:

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; and

h. Contractor may not impose Non-Quantitative Treatment Limitations (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.

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.

24. ACA Section 1557 Coordinator

a. As required by Section 1557 of the ACA, if Contractor employs fifteen (15) or more persons, then Contractor must designate and authorize at least one (1) employee to coordinate Contractor's compliance with its responsibilities under Section 1557 in its health programs and activities, including the investigation of any grievance communicated to it alleging noncompliance with Section 1557 or alleging any action that would be prohibited by Section 1557 (**"Section 1557 Coordinator"**). As appropriate, Contractor may assign one or more designees to carry out some of these responsibilities, but the Section 1557 Coordinator must retain ultimate oversight for ensuring coordination with Contractor's compliance.

b. Contractor must ensure that, at minimum, its Section 1557 Coordinator:

(1) Receives, reviews, and processes grievances, filed under the grievance procedure as set forth in § 92.8(c);

(2) Coordinates Contractor's recordkeeping requirements as set forth in § 92.8(c);

(3) Coordinates effective implementation of Contractor's language access procedures as set forth in § 92.8(d);

(4) Coordinates effective implementation of Contractor's effective communication procedures as set forth in § 92.8(e);

(5) Coordinates effective implementation of Contractor's reasonable modification procedures as set forth in § 92.8(f); and

(6) Coordinates training of relevant employees as set forth in § 92.9, including maintaining documentation required by such section.

[Remainder of page intentionally left blank]

Exhibit F – Insurance Requirements

Contractor shall obtain at Contractor's expense the insurance specified in this Ex. F prior to performing under this Contract. Contractor shall maintain such insurance in full force and at its own expense throughout the duration of this Contract, as required by any extended reporting period or continuous claims made coverage requirements, and all warranty periods that apply. 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. All coverage shall be primary and non-contributory with any other insurance and self-insurance, with the exception of professional liability and workers' compensation. Contractor shall pay for all deductibles, self-insured retention, and self-insurance, if any.

If Contractor maintains broader coverage and/or higher limits than the minimums shown in this insurance requirement exhibit, OHA requires and shall be entitled to the broader coverage and/or higher limits maintained by Contractor.

1. Workers' Compensation and Employers' Liability

All employers, including Contractor, that employ subject workers, as defined in ORS 656.027, shall comply with ORS 656.017, and provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under ORS 656.126(2). Contractor shall require and ensure that each of its Subcontractors complies with these requirements. If Contractor is a subject employer, as defined in ORS 656.023, Contractor shall also obtain employers' liability insurance coverage with limits not less than $500,000 each accident.

If Contractor is an employer subject to any other state's workers' compensation law, Contactor shall provide workers' compensation insurance coverage for its employees as required by applicable workers' compensation laws including employers' liability insurance coverage with limits not less than $500,000 and shall require and ensure that each of its out-of-state Subcontractors complies with these requirements.

2. Professional Liability

Contractor shall provide professional liability covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract by Contractor and Contractor's Subcontractors, agents, officers or employees in an amount of not less than $2,000,000 per claim and not be less than $4,000,000 annual aggregate limit.

If coverage is provided 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 Contractor shall provide continuous claims made coverage as stated below.

3. Commercial General Liability

Contractor shall provide commercial general liability insurance covering bodily injury and property damage in a form and with coverage that are satisfactory to the State. This insurance must include personal and advertising injury liability, products and completed operations, contractual liability coverage for the indemnity provided under this Contract, and have no limitation of coverage to designated premises, project, or operation. Coverage must be written on an occurrence basis in an amount not less than $1,000,000 per occurrence and not be less than $2,000,000 annual aggregate limit.

4. Automobile Liability Insurance

Contractor shall provide 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). Use of personal automobile liability insurance coverage may be acceptable if evidence that the policy includes a business use endorsement is provided.

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 combined average monthly Member Enrollment for this Contract and the separate Non-Medicaid and OHP Bridge-BHP Contracts. 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
449,001 to 549,000	$7,000,000

6. Excess/Umbrella Insurance

A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance. When used, all of the primary and umbrella or excess policies shall provide all of the insurance coverages herein required, including, but not limited to, primary and non-contributory, additional insured, Self-Insured Retentions (SIRs), indemnity, and defense requirements. The umbrella or excess policies shall be provided on a true "following form" or broader coverage basis, with coverage at least as broad as provided on the underlying insurance. No insurance policies maintained by the additional insureds, whether primary or excess, and which also apply to a loss covered hereunder, shall be called upon to contribute to a loss until Contractor's primary and excess liability policies are exhausted.

If excess/umbrella insurance is used to meet the minimum insurance requirement, the certificate of insurance must include a list of all policies that fall under the excess/umbrella insurance.

7. Additional Insured

All liability insurance, except for workers' compensation, professional liability, and network security and privacy liability, required under this Contract must include an additional insured endorsement specifying 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.

Regarding additional insured status under the general liability policy, we require additional insured status with respect to liability arising out of ongoing operations and completed operations, but only with respect to Contractor's activities to be performed under this Contract. The additional insured endorsement with respect to liability arising out of your ongoing operations must be on or at least as broad as ISO Form CG 20 10 and the additional insured endorsement with respect to completed operations must be on or at least as broad as ISO form CG 20 37.

8. Waiver of Subrogation

Contractor shall waive rights of subrogation which Contractor or any insurer of Contractor may acquire against OHA or State of Oregon by virtue of the payment of any loss. Contractor will obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not OHA has received a waiver of subrogation endorsement from Contractor or Contractor's insurer(s).

9. Continuous Claims Made Coverage

If any of the required liability insurance is on a claims made basis and does not include an extended reporting period of at least 24 months, then Contractor shall maintain continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the effective date of the Contract, for a minimum of 24 months following the later of:

a. Contractor's completion and OHA's acceptance of all services required under the Contract, or

b. OHA or Contractor termination of this Contract, or

c. The expiration of all warranty periods provided under this Contract.

10. Notice of Change or Cancellation

Contractor or its insurer must provide at least 60 days' written notice to OHA, via Administrative Notice, before cancellation of, material change to, potential exhaustion of aggregate limits of, or non-renewal of the required insurance coverage(s).

11. Insurance Requirement Review

Contractor agrees to periodic review of insurance requirements by OHA under this Contract and to provide updated requirements as mutually agreed upon by Contractor and OHA.

12. Certificate(s) and Proof of Insurance

Contractor shall provide to OHA the information requested in Sec. 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 provide to OHA certificate(s) of insurance for all required insurance before delivering any goods and performing any services required under this Contract. The certificate(s) shall list the State of Oregon, its officers, employees and agents as a certificate holder and as an endorsed additional insured. The certificate(s) shall also include all required endorsements or copies of the applicable policy language effecting coverage required by this Contract. If excess/umbrella insurance is used to meet the minimum insurance requirement, the certificate of insurance must include a list of all policies that fall under the excess/umbrella insurance. As proof of insurance OHA has the right to request copies of insurance policies and endorsements relating to the insurance requirements in this Contract.

13. State Acceptance

All insurance providers are subject to OHA acceptance. If requested by OHA, Contractor shall provide, via Administrative Notice, complete copies of insurance policies, endorsements, self-insurance

documents and related insurance documents to OHA's representatives responsible for verification of the insurance coverages required under this Exh. F.

14. 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 Ex. F, and is reasonably acceptable to OHA. Notwithstanding Sec. 12 of this Ex. F, Contractor shall furnish, via Administrative Notice, to OHA within five (5) Business Days after execution of this Contract, an acceptable insurance certificate to OHA for any insurance coverage required by this Contract that is fulfilled through self-insurance. Stop-loss insurance and reinsurance coverage against catastrophic and unexpected expenses may not be self-insured.

[Remainder of page intentionally left blank]

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

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

a. Contractor shall employ or enter into Network Provider agreements 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 Quality Assessment and Performance Improvement program 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, in the event of a Material Change to Delivery System, or as a result of OHA Monitoring, or EQRO review.

f. The accuracy of data and completeness submitted in the bi-annual DSN Provider Capacity Report will be periodically validated against available sources. If Provider data is submitted in an invalid format or contains invalid values for required data elements or both, OHA shall have the right to require Contractor to correct its data. If data errors are persistent, as defined by OHA, OHA shall have the right to require Contractor to, in addition to correcting its data, provide more frequent DSN Provider Capacity Reports to OHA, 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 the maintenance, reporting, and Monitoring and its oversight procedures to ensure compliance with the requirements of this Contract and Provider Network adequacy.

2. Delivery System Network Provider Monitoring and Reporting Requirements

a. Contractor shall provide OHA with a bi-annual DSN Provider Capacity Report no later than forty-five (45) days following the end of the first and third calendar quarters of each Contract Year. 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 submit an updated DSN Provider Capacity Report any time there is a Material Change to Delivery System. 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) Each bi-annual DSN Provider Capacity Report must follow the instructions and specifications provided by OHA, meeting all file extraction specifications, data field specifications, and minimum required data elements to be accepted by OHA. Instructions and templates for the DSN Provider Capacity Report are provided on the CCO Contract Forms Website.

(2) 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 availability 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 Culturally and Linguistically Appropriate Providers;

(8) Availability of oral and sign language interpreter, including Qualified and Certified Health Care Interpretation Services, and written translation services;

(9) Use of Telehealth modalities;

(10) Availability to make accommodations for physical accessibility;

(11) Provider data management, including Provider category, Provider specialty category, taxonomy code; and

(12) 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. Pursuant to 42 CFR § 438.206 and § 438.207, Contractor is required to demonstrate that all Covered Services are available and accessible to Members and that Contractor maintains a Provider Network with adequate Provider capacity. Contractor is required to submit an integrated annual DSN Report in a format determined by OHA that demonstrates how Contractor ensures, monitors, and evaluates adequate Provider capacity, considering geographic locations of Providers and Members, distance and travel time between Members and Providers, Member needs, coordination of care, and performance metrics. Through this annual DSN Report, Contractor shall provide information that corresponds with the categories described above, the details of which are specified in the Guidance Document provided on the CCO Contact Forms Website.

3. Cooperative Agreements with Publicly Funded Programs

Contractor shall ensure that relationships exist between Contractor and publicly funded health care and service programs in order to implement and formalize coordination. OHA shall have the right to request, and Contractor shall provide within the timeframe specified by OHA, copies of Contractor's cooperative

agreements with publicly funded programs, which may include, but are not limited to: Local Mental Health Authority, Community Mental Health Programs, Type B AAA, State APD district offices, and Local public health authority. OHA shall have the right to request, and Contractor shall provide within the timeframe specified by OHA, any additional information about Contractor's relationships with publicly funded programs.

4. Cooperative Agreements with Community Social and Support Service and Long Term Care

a. Contractor shall ensure that the relationships described below exist between Contractor and Community social and support service and long term care organizations. OHA shall have the right to request, and Contractor shall provide within the timeframe specified by OHA, copies of Contractor's cooperative agreements with such organizations and any additional information about Contractor's relationships with such organizations.

(1) Referral and cooperative arrangements with culturally diverse social and support services organizations, as required under the applicable provisions of Ex. 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 Ex. B, Part 4 of this Contract.

(3) Cooperative arrangements and agreements with ODHS Child Welfare offices to assure timely Assessments for Member children placed under Child Welfare custody, as required by Ex. 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. b 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 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.

[Remainder of page intentionally left blank]

Exhibit H – Value Based Payment

Contractor shall demonstrate, as specified below, how it will use Value-Based Payment (VBP) 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 VBPs, 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 Annual Requirement

For Contract Year seven (2026), Contractor shall meet the annual VBP targets specified in Sec. 4 of this Ex. H. The VBP components specified in Sec. 4 are defined in the Health Care Payment Learning and Action Network's ("LAN") "Alternative Payment Model Framework White Paper Refreshed 2017" (http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf). 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 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

For Contract Year seven (2026), Contractor shall maintain VBPs for each of the five (5) care delivery areas established in Contract Years one through six (2020-2025). In those previous Contract Years, Contractor was required to develop new, or expand from an existing contract, VBPs in care delivery areas that include Hospital care, maternity care, Behavioral Health care, Oral Health care, and children's health. The term "expand 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 shall use the VBP Technical Guide for Coordinated Care Organizations for the care delivery area VBP specifications. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher throughout the Term of this Contract. In Contract Year seven (2026), Contractor shall continue to meet care delivery area VBP requirements for a minimum of twelve (12) months for each of the aforementioned five (5) care delivery areas.

3. Patient-Centered Primary Care Home (PCPCH) VBP Requirements

a. For Contract Year seven (2026), Contractor shall continue to provide per-member-per-month (PMPM) payments to PCPCH clinics established during Contract Years one through six (2020-2025). Contractor shall provide PMPM 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 nine (9) Contract Years of this Contract. OHA's VBP Technical Guide will include guidance to assist Contractor in complying with these requirements.

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 VBP targets.

4. VBP Targets by Year

For Contract Year seven (2026), Contractor shall maintain the annual VBP targets established for Contract Year five (2024), which are as follows:

a. For services provided in Contract Year five (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 Secs. 6 through 9 below of this Ex. H. By January 21, 2026, Contractor shall provide to OHA, via Administrative Notice, the name and contact information of Contractor's designee for all VBP communications. Contractor shall similarly notify OHA with ten (10) days of any change in either its VBP designee's name or contact information, or both. 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.

(1) Contractor is encouraged to use metrics defined by the National Quality Forum or similar national measure steward.

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 Year seven (2026) shall include all of the following:

a. By May 1, 2026, Contractor shall submit to OHA, via Administrative Notice, the following:

(1) *VBP Data Template.* The Template, which must be submitted in Excel format, is posted on OHA's VBP webpage at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx. The 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.

(2) *VBP Questionnaire.* The questionnaire, which must be submitted in Word format, is posted on OHA's VBP webpage. Contractor shall use the questionnaire to report information that includes but is not limited to the following:

(a) Describe the activities regarding the VBP arrangements during the previous Contract Year;

(b) 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 inequities, or both complex care needs and being at risk for health inequities, and compare and describe any modifications to the plans;

(c) Report implementation progress for the care delivery areas that were implemented in previous Contract Years; and

(d) Provide any additional information requested by OHA on VBP development and implementation.

b. 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.

c. Contractor's VBP data reporting obligations for Contract Year nine (2028) shall survive termination of this Contract. Contractor shall submit to OHA all required VBP data for Contract Year seven by September 30, 2029. Such data shall be submitted to OHA in accordance with Para. c of this Sec. 6, Ex. H.

d. Contractor shall make all reasonable efforts to participate in up to nine (9) OHA-coordinated CCO VBP workgroup meetings each year, either virtually or in person, and to share best practices in its VBP development and implementation.

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.

[Remainder of page intentionally left blank]

Exhibit I – Grievance and Appeal System

Contractor's Grievance and Appeal System shall consist of the procedures Contractor follows with respect to Grievances, Adverse Benefit Determinations, Appeals of Adverse Benefit Determinations, resolutions of Appeals, and access to Contested Case Hearings, as well as the processes to collect and track information about these procedures, in accordance with OAR 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860, 42 CFR § 438.400 through § 438.424, this Ex. 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 Ex. 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 Ex. 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 Ex. 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 Ex. 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 Ex. 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, Member Representatives, and Providers with the Member's written consent 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. d-i 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 when the Member makes the oral request of Contractor. Contractor shall use the date of initial Member contact, not the date when the pertinent internal department receives the request, unless it is the same date as initial contact.

(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 410-141-3875, available and accessible to Members in all administrative offices open to the public, where applicable.

(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) Consistent with confidentiality requirements, Contractor shall ensure its staff designated to receive Appeals begins to obtain documentation of the facts concerning the Appeal upon receipt of the Appeal. Contractor's Appeal process shall take into account all comments, documents, records, and other information submitted by Member or Provider 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 OHA's 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 and Member's Representative, if applicable, 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. Additional resolution time may be requested only if the extension is in the Member's best interest to fully resolve the Grievance.

(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 and Member's Representative, if applicable, a written Notice of Adverse Benefit Determination.

a. Contractor's NOABD must meet the language and format requirements in Secs. 4 and 5 of Ex. B, Part 3 of this Contract including, without limitation, translating an NOABD for those

Members who speak Prevalent Non-English Languages and be consistent with the requirements of OARs 410-141-3580, 410-141-3585, 410-141-3885,[49] and 42 CFR § 438.10 and as set forth in the associated Guidance Document located on the CCO Contract Forms Website.

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 a Clean Claim.

[49] This existing OAR will be updated effective 1/1/2026.

(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 seven (7) calendar days following receipt of the request for service, consistent with 42 CFR § 438.210(d)(1)(i)(B), 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 Sub-Sub.Para. (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 (including as necessary multiple calls at different times of day) 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 NOABDs relating to NEMT Services, Contractor shall comply with the additional requirements as described in OAR 410-141-3920.

(6) 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 Sub-Sub.Para. (i) above of this Ex. I, Sec. 3, Para. b, Sub.Para. (6) (a), Contractor shall give the Member written notice, and shall make reasonable effort (including as necessary multiple calls at different times of day) 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.

(7) 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,[50] 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) An Appeal can be filed orally or in writing. There is no requirement to file a written appeal after filing an Appeal orally.

(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 410-141-3875. 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 § 438.406(b)(4).

(4) Provide Appeal information to Members in accordance with Ex. B, Part 3, Sec. 4 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.

[50] This existing OAR will be updated effective 1/1/2026.

(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, within two (2) days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if the Member disagrees with that decision, and make reasonable effort (including as necessary multiple calls at different times of day) 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 as expeditiously as the Member's health condition requires and 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. The timeline for an expedited Appeal requested orally shall begin when there is established contact made between the Member and Contractor.

(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 (including as necessary multiple calls at different times of day) 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) A request for an expedited Appeal for a service that has already been provided to the Member (post-service) will not be granted. Contractor shall transfer the Appeal to the timeframe for standard resolution.

(f) 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 effort (including as necessary multiple calls at different times of day) 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.

(g) 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 (including as necessary multiple calls at different times of day) 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 Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx.

iii. Explanation to the Member that an expedited Hearing will not be granted for post-service denials;

iv. The right to continue to receive benefits pending a Contested Case Hearing and how to do so;

v. 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 completion of the initial Contractor 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 (2) 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 CCO 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 410-141-3890.

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 as described in OAR 410-141-3900[51] and OAR 410-141-3905:

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. A request for an expedited Contested Case Hearing for a service that has already been provided to the Member (post-service) will not be granted.

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, Sec. 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 all of the following occur:

(1) The Appeal or Contested Case Hearing request involves the termination, suspension, or reduction of previously authorized services;

(2) An authorized Provider ordered the services;

(3) The period covered by the original authorization has not expired; and

(4) The Member timely files for continuation of benefits.

c. Duration of Continued Benefits

(1) Continuation of benefits pending Appeal resolution

[51] This existing OAR will be updated effective 1/1/2026.

If, at the Member's request, Contractor continues or reinstates the Member's benefits while the Appeal is pending, pursuant to 42 CFR § 438.420(c) and OAR 410-141-3910 the benefits must be continued until one of the following occurs:

(a) The Member withdraws the Appeal; or

(b) 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) and OAR 410-141-3910 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 the date of 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) and OAR 410-141-3910, 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

If Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services, Contractor shall provide the services or pay for the services or both in accordance with OAR 410-141-3910.

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 records, 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 Member's 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. Grievance and Appeal System, Policies and Procedures, and Member Notice Templates

a. The following apply to Contractor's Grievance and Appeal System, policies and procedures (P&Ps) related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System:

(1) Contractor shall develop and maintain written P&Ps for its Grievance and Appeal System that comply with the requirements of this Contract and Applicable Laws. Contractor shall submit its Grievance and Appeal System P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

(2) In addition to OHA's right to request, and Contractor's obligation to provide OHA with its Grievance and Appeal System P&Ps under Sub.Para. (1) above of this Para. a, for the purpose of conducting a compliance review, OHA shall also have the right to request, and Contractor shall provide OHA with, copies of its Grievance and Appeal System P&Ps, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System. The foregoing compliance review requests may be made, but are not required to be made, by OHA in connection with or following a quarterly review conducted pursuant to Ex. I, Sec. 10, Para. b, or a Contested Case Hearing. Contractor shall provide all documentation requested under this Sub.Para. (2) to OHA via Administrative Notice within five (5) Business Days of OHA's request. Without limiting any other provision in this Contract, in the event OHA, CMS, or EQRO determine Contractor's 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.

(3) Consistent with Ex. B, Part 3, Sec. 4, Para. g, Contractor shall obtain OHA approval of materials provided directly to and otherwise made available to Members regarding Contractor's Grievance and Appeal system, prior to implementing and providing such materials to Members.

(4) Contractor's Grievance and Appeal System P&Ps, 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 (as indicated in

OHA's Member Handbook Evaluation Criteria located on the CCO Contract Forms Website) 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) Grievance System Report, which must be submitted to OHA using the form available to Contractor on the CCO Contract Forms Website. Contractor must analyze its Grievance and Appeal System using the data it has collected from Contractor's and its Subcontractor's Grievance and Appeal logs as well as any and all other data collected as a result of Contractor Monitoring its own and its Subcontractor's Grievance and Appeal System. Contractor shall, in its Grievance System Report, demonstrate how Contractor has used and continues to use its own data and the data it has collected from its Subcontractor(s) to maintain an effective process for Monitoring, evaluating, and improving access and quality of the services to Members in a manner that is responsive to the specific needs of each Member;

(2) Grievance and Appeal Log, which shall include information about Prior Authorizations requests and denials pursuant to ORS 414.072 and in accordance with OAR 410-141-3835, in the format provided by OHA and available on the CCO Contract Forms Website;

(3) Samples of NOABD and corresponding Prior Authorization (PA) documentation. Contractor's PA template shall include, at a minimum: date of the request for the service, name and credentials of the clinician who reviewed the PA and made the final outcome decision, 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. OHA reserves the right to conduct stratified sampling of Contractor's Grievance and Appeal log. The sample size per quarter is a minimum of twenty NOABDs and a maximum of 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; and

(4) Any other related documentation requested by OHA.

c. 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 within thirty (30) days of notification by CMS, OHA, or EQRO of non-compliance with this Contract, Applicable Laws, or both. If OHA does not approve of Contractor's Grievance and Appeal System, Contractor shall follow the process set forth in Sec. 5, Ex. D to this Contract.

d. 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.

e. If Contractor has Delegated, in part or in full, the Monitoring of any Grievance and Appeal System activity(ies) to a Subcontractor, Contractor shall submit records of such Monitoring to OHA, federal, state, and OHA-contracted auditors, upon request. Such Subcontractor records shall provide evidence of compliance, as required under 42 CFR § 438.230, with the requirements of OAR 410-141-3835 through 410-141-3915, 42 CFR §§ 438.400 through 438.424, and this Ex. I. The records submitted under this Para. e shall include any Corrective Actions initiated by Contractor as a result of Subcontractor Monitoring, up to and including termination of Subcontractor. Contractor shall submit all records requested under this Para. e 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.

[Remainder of page intentionally left blank]

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 the ACA; 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) Data from OHA's Measures and Outcome Tracking System (MOTS) and from the data system designated by OHA to replace 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;

(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 Ex. G to this Contract;

(11) Member Enrollment;

(12) Services provided to Members for pharmacy services; and

(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 Ex. 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; and

(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.

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. Each Contract Year, 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 each Contract Year. The Updated HIT Roadmap for each Contract Year must clearly identify any new information, activities, milestones, timelines which were not included in the HIT Roadmap for the previous Contract Year. In support of the Updated HIT Roadmap, Contractor shall submit an annual HIT data file with its Updated HIT Roadmap consisting of its contracted organizations and the data specified by OHA in the annual HIT data reporting Guidance Document. 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) HIT tools in use by each of its contracted physical, Behavioral, and Oral Health Providers:

(a) EHR(s) vendor/product;

(b) HIE tool(s); and

(c) Tools used for hospital event notification.

(3) Description of the progress made towards meeting EHR adoption targets, including, without limitation, the proportion of physical, Behavioral and Oral Health Providers adopting EHRs 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) Description of the progress made towards achieving HIE access targets for both Care Coordination and identify both (i) the proportion of those physical, Behavioral and Oral Health Providers who have access to HIE for Care Coordination and (ii) the proportion using HIE for Care Coordination.

(5) Description of 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.

(6) Description of how Contractor used and supported providers and community-based organizations to use HIT to support social needs screening and referrals for addressing social determinants of health needs, including whether referrals were Closed Loop Referrals (e.g., CIE).

(7) Description of Contractor's progress and plans to support and incentivize HRSN Service Providers to adopt and use technology for Closed Loop Referrals.

(8) Information on any CIE requirements for HRSN Service Providers, including Contractor's exceptions process.

(9) All information collected by Contractor for the elements listed below for Component 1 of the "Social Determinants of Health: Social Needs Screening and Referral Measure" (**"SDOH Measure"**) for Measurement Year 2025. As stated in Ex. B, Pt. 10, Sec. 4, the specifications for all metrics, including the SDOH Measure, are located at: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx. Further, OHA maintains the following webpage with resources specific to the SDOH Measure: https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx.

(a) *Element 3:* Systematic assessment of whether and where screenings are occurring by Contractor and provider organizations, including whether organizations are screening Members for (1) food insecurity, (2) housing insecurity, and (3) transportation needs.

(b) *Elements 6 and 7:* Identification of screening tools or screening questions in use by Contractor and provider organizations, including available languages and whether tools and questions are OHA-approved or exempted.

(c) *Element 13:* Environmental scan of data systems used in Contractor's Service Area to collect information about Members' social needs, refer Members to community resources, and exchange social needs data.

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)-(6) above of 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 amended and adopted federal regulations set forth in the CMS Interoperability and Patient Access Final Rule and the CMS Interoperability and Prior Authorization Final Rule (collectively, the "CMS Interoperability Rules") and OAR 410-141-3591.[52] The provisions of the CMS Interoperability ~~and Patient Access Final Rule,~~Rules with

[52] This existing OAR will be updated effective 1/1/2026.

which Contractor is required to comply ~~are~~include but are not limited to: 42 CFR § 438.242(b)(5)-(6), 42 CFR § 457.1233(d), and 42 CFR § 438.62(b)(1)(vi) & (vii). These rules include but are not limited to 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.

(1) In compliance with 42 CFR § 438.242(b)(5)(iii) and 42 CFR § 431.60(f), Contractor shall submit to OHA, via Administrative Notice, aggregated, de-identified data on Patient Access API usage by March 31st of each Contract Year for the prior Contract Year. OHA will provide a Guidance Document and reporting template to assist Contractor in complying with this provision. OHA will require Contractor to submit only the data necessary for OHA to comply with the requirement to report such data to CMS.

[Remainder of page intentionally left blank]

Exhibit K – Social Determinants of Health and Equity

1. Community Advisory Council

To ensure that the health care needs of all Members of the Community within Contractor's Service Area are being addressed, Contractor shall, in accordance with ORS 414.575, 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;

(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; and

(3) Contractor shall seek an opportunity for Tribal participation on the CAC by bringing nominee(s) to the attention of the CAC Selection Committee as follows:

(a) In a Service Area where only one Federally Recognized Tribe exists, the CCO shall seek one Tribal representative to serve on the CAC;

(b) In a Service Area where multiple Federally Recognized Tribes exist, the CCO shall seek one representative from each Tribe to serve on the CAC; and

(c) In a metropolitan Service Area where no Federally Recognized Tribe exists, Contractor shall solicit the Urban Indian Health Program for a representative to serve on the CAC.

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 one hundred twenty (120) 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; (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) and 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 (6) 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 Community Advisory Council but not in the capacity of a Consumer Representative.

g. Notwithstanding Paras. 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 one hundred twenty (120) 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 the contact information for its CAC Coordinator on its website and indicate that the CAC Coordinator is the conduit to contact the CAC Chairperson and other CAC members.

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 SHARE spending decisions as set forth in OAR 410-141-3735.

(3) Fulfilling the Contractor-determined role for the CAC in Flexible Services at the community level, 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 its 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. [RESERVED]

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[53] and in compliance with ORS 414.575. The purpose of a CHA is to assess the health status, needs, and assets 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. Pursuant to ORS 414.577, as amended by Section 2 of Enrolled House Bill 2208 (2025), 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, Community Mental Health Programs, Local Planning Committees, 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:

[53] This existing OAR will be updated effective 1/1/2026.

(1) Meaningfully and systematically engage representatives of local governments, Tribal governments, community partners and stakeholders, and critical populations to assess the Community health needs and assets of Contractor's Service Area.

(a) Contractor may utilize the community engagement checklist to support meaningful engagement throughout the CHA and CHP process, which is provided and made available by OHA's Equity & Inclusion Division at the following URL: https://www.oregon.gov/oha/EI/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, Oral Health care Providers;

vi. Federally Qualified Health Centers,

vii. Indian Health Care Providers,

viii. Tribal Liaison

ix. Traditional Health Workers,

x. Culturally specific organizations, including Regional Health Equity Coalitions, and

xi. Representatives from populations who are experiencing health inequities.

(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.

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, sex, gender identity, sexual orientation, and other applicable identifying factors, and must work with community organizations and available data sources to obtain information on gender identity and sexual orientation;

(2) Identify and describe the health status, needs, and assets 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, sex, gender identity, 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;

(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. 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 OHA's Equity and Inclusion Division in developing its baseline data.

h. Pursuant to OAR 410-141-3730, Contractor shall update its CHA every five years; however, nothing in this Contract precludes Contractor from updating the CHA more frequently. By December 31 of the Contract Year in which the updated CHA is completed, Contractor shall submit to OHA, via Administrative Notice, an Attestation stating that its updated CHA meets the requirements specified in the document identifying the CHA content requirements. Contractor shall provide to OHA, via Administrative Notice, the updated CHA that is the basis of its Attestation within five (5) Business Days of request by OHA. Without limiting any other rights and remedies OHA may have under this Contract, OHA has the right, in accordance with Ex. B,

Part 9, to impose one or more Sanctions if it determines that Contractor's Attestation is false. In the event that Contractor's updated Community Health Improvement Plan (CHP) will be completed in the year following completion of the updated CHA, Contractor may instead submit the aforementioned documents for the updated CHA in the following year with the updated CHP. Contractor shall promptly make its updated CHA widely available to the public, including posting on Contractor's website.

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 (CHP) 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, Tribal governments, community partners and stakeholders, and critical populations to create its CHP, which, pursuant to ORS 414.577, as amended by Section 2 of Enrolled House Bill 2208 (2025), must include local public health authorities, Local Mental Health Authorities, Community Mental Health Programs, Local Planning Committees, Hospitals, Indian Health Care Providers, Tribal Liaison, and other CCOs, and Federally Recognized Tribes when such parties share Contractor's Service Area.

(1) Contractor may utilize the community engagement checklist to support meaningful engagement throughout the CHA and CHP process, which is provided and made available by OHA's Equity & Inclusion Division at the following URL: https://www.oregon.gov/oha/EI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf.

(2) The entities within Contractor's Service Areas that Contractor shall engage in the creation of the CHP must include, without limitation:

(a) County and city government representatives,

(b) Federally Recognized Tribes (if not already collaborating on a shared CHA),

(c) SDOH-E Partners,

(d) Local Mental Health Authorities and Community Mental Health Programs,

(e) Physical, Behavioral, and Oral Health care Providers,

(f) Federally Qualified Health Centers,

(g) Indian Health Care Providers,

(h) Tribal Liaison,

(i) Traditional Health Workers,

(j) Culturally specific organizations, including Regional Health Equity Coalitions, and

(k) Representatives from populations who are experiencing health inequities.

(3) Contractor shall utilize Guidance Documents and other resources provided by OHA to plan, develop, and draft its CHP. Such Guidance Documents and other resources are

found at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/chachp-technical-assistance.aspx.

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. g, 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) 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, sex, gender identity, sexual orientation, and other relevant factors; and

(7) Based on such findings, identify and prioritize strategies to reduce 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 strategies which can be found on OHA's website at: https://healthiertogetheroregon.org/.

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. Pursuant to OAR 410-141-3730, Contractor shall update its CHP every five years; however, nothing in this Contract precludes Contractor updating the CHP more frequently. Contractor shall provide a copy of its updated CHP to OHA, via Administrative Notice, by December 31 of the Contract Year in which the CHP was completed. Contractor shall include with its submission a copy of the associated new CHA.

j. Within sixty (60) days after OHA receives Contractor's CHP, OHA will notify Contractor of the approval status of the CHP and whether OHA requires additional time for review. In the event OHA does not approve the CHP, Contractor shall, in order to remedy the deficiencies in its CHP, follow the process set forth in Sec. 5, Ex. D of this Contract. Upon OHA's approval of the CHP, Contractor shall post its CHP on its website.

k. In the event OHA determines Contractor's then-current CHP no longer serves its intended purpose, OHA has the right, pursuant to OAR 410-141-3730, to require Contractor to update its CHP in less than five (5) years.

l. Contractor shall provide an Annual CHP Progress Report to OHA detailing the progress it has made in developing or implementing its CHP. Contractor shall submit its Annual CHP Progress Report to OHA, via Administrative Notice, no earlier than June 30 and no later than December 31 of each Contract Year, starting in the second year of Contractor's new CHP cycle using the template provided on the CCO Contract Forms Website.

(1) All Annual CHP Progress Reports shall document the progress made toward the goals, strategies, and measures 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.

8. Social Determinants of Health and Equity Spending Programs: SDOH-E Partners and SHARE

a. Supporting Health for All through Reinvestment. Contractor shall spend a portion of its previous calendar year's net income or reserves that exceed the financial requirements prescribed by OHA on services designed to address health disparities and SDOH-E. In doing so, Contractor shall comply with OAR 410-141-3735, ORS 414.572, the CCO financial solvency administrative rules in OAR 410-141-5000 *et seq*, this Contract, and SHARE program guidance provided on the CCO Contract Forms Website.

b. As used in this Sec. 8 and SHARE program guidance, "Designation" means the amount of funding Contractor chooses and reports as a contribution for SHARE spending; the Designation must not be less than Contractor's minimum SHARE Obligation. "Obligation" means the amount of funding Contractor is required to contribute based on adjusted net income and in accordance with formula set forth in OAR 410-141-3735(3).

c. For all Contract Years, expenditures made under SHARE must meet all requirements specified in the applicable OARs and in this Contract, including without limitation:

(1) SHARE spending priorities selected by Contractor based on:

(a) 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; and

(b) At least one priority that aligns with the OHA-designated Statewide priority for SDOH-E spending in Housing-Related Services and Supports, including Supported Housing, as defined in this Contract. Contractor shall comply with future statewide priorities identified by OHA.

(2) A portion of Contractor's SHARE 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, Memorandum of Understanding, or other form of agreement including a grant agreement with each SDOH-E Partner. The agreement must define the services to be provided and

Contractor's data collection methods as provided in this Contract. The agreement must meet the minimum requirements listed in the program Guidance Documents located on OHA's SHARE webpage at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx.

(3) Contractor shall designate a role for the CAC in relation to SHARE spending decisions and have a conflict of interest policy that applies to its CAC members and accounts for financial interests related to SHARE and other SDOH-E spending, as described in OAR 410-141-3735.

d. Contractor shall annually submit to OHA, via Administrative Notice, an Attestation that its SDOH-E spending for SHARE complies with the requirements of this Sec. 8, OAR 410-141-3735, and in accordance with the instructions set forth in the SHARE Attestation template that Contractor shall be required to use. Contractor shall submit its SHARE Attestation by December 31 of each Contract Year. The SHARE Attestation template required to be used will be provided by OHA on the CCO Contract Forms Website. Without limiting any other rights and remedies OHA may have under this Contract, OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanctions if it determines that Contractor's Attestation is false.

e. By June 30 of each Contract Year, Contractor shall publicly post information about its SHARE spending made in the prior Contract Year. Contractor will have the option, but not the obligation, to use an OHA template for its public posting, which is available on the CCO Contract Forms Website. Contractor shall publicly post the required SHARE spending information on its own website. Contractor may also, at its own option, publicly release the SHARE spending information using other means. Regardless of whether Contractor uses the OHA optional template, Contractor shall include, at a minimum, the following information in its required public posting:

(1) How spending aligns with Contractor's CHP priorities.

(2) How Contractor selected its SDOH-E Partners.

(3) Descriptions of its SHARE spending, including but not limited to SDOH-E Partner names, project activities, and amounts allocated to each SDOH-E Partner.

f. Contractor shall annually submit to OHA a report on its SHARE Obligations and expenditures. Contractor shall submit the SHARE report using the designated worksheet in the Ex. L Financial Reporting Template. The SHARE report must be submitted to OHA, via Administrative Notice, by the due dates for initial and audited annual submissions indicated in the required template. Contractor shall use the SHARE worksheet to identify total SHARE spending and also break down the total spend by identifying the specific amount Contractor provided to each SDOH-E Partner (as described in this Ex. K). The Ex. L Financial Reporting Template is provided by OHA on the CCO Contract Forms Website.

g. The portion of required SHARE spending for each Contract Year of this Contract must be spent down within three (3) years. Contractor may request from OHA an extension of time of up to one (1) year from OHA's initial approval to completely spend down its SHARE Designation. All such requests must be made at least ninety (90) days prior to the expiration of the three-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. Contractor may choose to utilize one or both of the following two flexibilities in its SHARE spending:

(1) *Carry forward:* Contractor may designate more than its required minimum SHARE Obligation for a given year. The excess amount may be carried forward and used to satisfy all or a portion of any of the three (3) succeeding Contract Years' minimum SHARE requirements. The carry forward flexibility is available effective as of Contractor's SHARE Attestation that was due in Contract Year six (2025), which pertains to Contactor's 2024 Ex. L financial reporting.

(2) *Set-aside:* Contractor may set aside up to twenty-five percent (25%) of its annual SHARE Designation to allocate to SDOH-E Partners and report to OHA within three years. The amount will be counted in the current year's Designation, but Contractor must allocate and spend the amount within three (3) years.

h. In the event Contractor terminates this Contract, or has its Contract terminated by OHA, prior to SHARE funds being spent down, as required under this Contract, all remaining SHARE funds must be spent in compliance with these Contract terms as a part of its Transition Plan.

9. Flexible Services

a. In addition to Covered Services, Contractor shall provide and cover the cost of Flexible Services in accordance with criteria set forth in OAR 410-141-3845[54] and 45 CFR § 158.150 (including those services identified in 45 CFR § 158.151). Flexible Services must be coordinated by Contractor but may be provided in collaboration with the PCPCH

b. s or other PCPs in Contractor's Service Area. Flexible Services must be administered in accordance with Contractor's policy.

c. Contractor's Flexible Services at the community level shall promote alignment with its then-current CHP.

d. Services covered under this Contract may be expanded to include Flexible Services in compliance with Contractor's policy. In addition, each Member, and as may be appropriate, the Family of the Member, must agree that Flexible Service is an acceptable complementary service.

e. Contractor shall develop and maintain written Flexible Service Policies which shall address Contractor's policies and procedures for the provision of Flexible Services. Contractor's Flexible Service Policies must comply with OAR 410-141-3845 and OAR 410-141-3500, and also identify:

(1) How Contractor will decide whether and when Flexible Services are provided and paid for;

(2) What types of Flexible Services are provided and paid for;

(3) How Flexible Service providers can become eligible to provide services to Contractor's Members;

(4) Processes for requesting funding for Flexible Services and processes regarding the awarding of funds for Flexible Services;

(5) Processes to enable alignment between Contractor's Flexible Services at the community level and CHP priorities;

[54] This existing OAR will be updated effective 1/1/2026.

(6) Procedures and processes for Monitoring Flexible Services spending through an analysis of the effectiveness of the spending and how such analysis has impacted any change in Contractor's Flexible Service Policies;

(7) The role of the CAC and Tribes in spending decisions for Flexible Services at the community level; and

(8) Processes to notify individual Members and Providers of the outcome of Member-level Flexible Services requests.

f. Contractor's Flexible Service Policies must enable a Participating Provider to order and supervise the delivery of Flexible Services.

g. Contractor shall submit its Flexible Service Policies to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

10. Health Equity Plan

Since Contract Year one (2020), Contractor has been required to develop and implement a Health Equity Plan (HEP) designed to address the cultural, socioeconomic, racial, and regional disparities in health care that exist among Contractor's Members and in the Communities within Contractor's Service Area. OHA has been utilizing the HEP as a mechanism to drive organizational change by enhancing the capacity of CCOs to promote Health Equity through direct actions, resource allocation, organizational commitment, community partnerships, and ongoing accountability. The HEP has allowed OHA to monitor CCOs' efforts and provided opportunities for OHA to offer direction and technical assistance when necessary and upon request. It has been OHA's intention to retire the HEP when OHA determines that it has served its purpose.

To this end, Contract Year seven (2026) is the final year for the HEP. Although this Sec. 10 reflects the conclusion of the HEP as a deliverable, the advancement of Health Equity remains a Contract requirement.

a. Final Health Equity Plan Report

(1) OHA will develop the Final HEP Report template during the first half of Contract Year seven (2026), with the opportunity for CCOs to provide input. OHA will provide a Guidance Document to assist Contractor with preparing its Final HEP Report. OHA will make both documents available on the CCO Contract Forms Website. OHA will also be available for technical assistance.

(2) In the Final HEP Report, OHA will require Contractor to provide information about each of the focus areas identified in Ex. K, Sec 10, Para. b, Sub.Para. (2), Sub-Sub.Paras. (a-e) of the 2025 Amended and Restated Contract (Contract Year six). The focus areas from the 2025 Amended and Restated Contract were and the information about which Contractor will be required to provide information are: (i) REALD & SOGI; (ii) using CLAS Standards as an organizational framework to advance Health Equity; (iii) people with disabilities and LGBTQIA2S+ people; (iv) CCO community engagement activities; and (v) continued development of an organizational Health Equity infrastructure. The information that will be required to be included in the Report will include, for each focus area, but will not be limited to, the following:

(a) *Assessment of overall progress:* Evaluation of the extent to which Contractor's HEP goals and activities have been achieved, including progress towards reducing health inequities within its Service Area. This may include a progress summary, a

review of outcomes and metrics, and an assessment of community engagement; and

(b) *Identification of gaps and opportunities for improvement:* Identification of any gaps, challenges, or barriers encountered during HEP implementation and description for opportunities for future improvement in advancing HE. This may include how to strengthen and sustain HE efforts.

(3) Contractor shall submit its Final HEP Report to OHA, via Administrative Notice, by the applicable due date, which are as follows:

(a) If Contractor ~~is accredited by~~has earned NCQA ~~for HE~~Health Outcomes Accreditation (formerly known as Health Equity Accreditation) or has formally engaged NCQA in the survey process for ~~HE~~such accreditation, then Contractor shall submit its Final HEP Report no later than September 1, 2026. Contractor must indicate in the Final HEP Report whether it is accredited or under survey. If under survey, then Contractor's Final HEP Report must include the official notice from NCQA that states the survey date.

(b) If Contractor is neither accredited nor under survey, then Contractor shall submit its Final HEP Report no later than November 30, 2026.

(4) Notwithstanding the public posting of Contractor's Final HEP Report pursuant to Sec. 14 of Ex. D, OHA reserves the right to utilize any and all information provided in Contractor's Final HEP Report in other publicly available documents, with the opportunity for Contractor to redact any Protected Information or Trade Secrets (or both).

b. Health Equity Administrator

Contractor shall employ a Health Equity Administrator (HEA) who is accountable for preparation of the Final HEP Report and the development and implementation of Contractor's Health Equity related organizational initiatives, including NCQA HE accreditation. Contractor must ensure the designated HEA meets the following characteristics: (a) must be a director level employee; (b) must have budgetary authority; (c) must demonstrate knowledge and expertise in Health Equity; and (d) must be able lead Health Equity organizational efforts and to allocate the necessary time and organizational resources. Contractor shall document any changes in its HEA's roles and responsibilities or areas of accountability or both and promptly notify OHA, via Administrative Notice, of any such changes. Contractor shall provide Administrative Notice to OHA within ten (10) days after any change in either its HEA's name, contact information, or both.

11. Traditional Health Workers

a. Contractor shall implement the Traditional Health Worker (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 Equity and Inclusion Division THW Commission best practices which includes Contracting with Community based organizations and with THWs who work as independent contractors and may not be associated with Community-based organizations (such as Doulas), as described in OHA's THW Toolkit found at the following URL: https://www.oregon.gov/oha/EI/Pages/Info-Health-Systems-Providers-THWs.aspx;

(5) Account for and track utilization of services 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.

(7) Contractor shall annually submit to OHA a THW Integration and Utilization Plan report as described in the associated Guidance Document provided by OHA on the CCO Contract Forms Website. The report shall include information about Contractor's progress in the activities planned for the current Contract Year.The annual THW Integration and Utilization Plan report must be submitted to OHA, via Administrative Notice, by 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 annual THW Integration and Utilization Plan report, Contractor shall follow the process set forth in Sec. 5 of Ex. D to this Contract.

(a) Contractor may, at its discretion, include in its annual report information about additional investments that support THWs and THW programs. These may include but are not limited to investments in health information technology, programmatic supports, workforce trainings, and infrastructure improvements.

(8) Contractor may request that OHA's Equity and Inclusion Division provide its technical assistance with Contractor's implementation of its THW Integration and Utilization Plan.

b. Contractor shall establish a THW Payment Grid that documents Contractor's payment strategies for THW services and programs. Contractor shall use the template provided by OHA on the CCO Contract Forms Website. Contractor shall provide its THW Payment Grid to OHA, via Administrative Notice, by no later than November 15 of that same Contract Year. OHA will then post Contractor's THW Payment Grid at the following URL: https://www.oregon.gov/oha/EI/Pages/CCO-Traditional-Health-Worker-Deliverables.aspx.

The THW Payment Grid must include different sustainable payment strategies, such as Fee-for-Service and alternative payment models. In the context of the THW Payment Grid, "sustainable payment strategies" means strategies that enable Contractor to pay THWs as a part of Provider contracting or direct employment rather than through limited scope or duration grants or agreements. The THW Payment Grid shall only include Tribal THWs if this type of THW was in effect for some or all of the reporting period.

c. Contractor shall work in collaboration with OHA's THW Commission to implement prevailing best practices and models to enhance organizational capacity to:

(1) Contract with Community-based organizations and with THWs who work as independent contractors and may not be associated with Community-based organizations (such as Doulas),

(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/EI/Pages/Info-Health-Systems-Providers-THWs.aspx.

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 ensuring that Contractor is:

(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) Designing and implementing Contractor's THW Integration and Utilization Plan;

(5) Providing technical assistance to help THWs become enrolled as Provider with Contractor;

(6) Assisting and coaching Members in utilizing Contractor's THW Providers and services;

(7) Providing assistance and support for establishing THW payments and rates;

(8) Providing 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. Contractor shall:

(1) Provide OHA with its THW Liaison job description for review and approval as set forth above in Para. d of this Sec. 11, Ex. K;

(2) Include in its Member Handbook the benefits and availability of THW services;

(3) Provide information, whether specific to an individual or a general method that does not identify a specific individual, about how to contact 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 Member education and outreach materials and other means and

methods. All Member materials must be developed in accordance with the requirements specified in Ex. B, Part 3, Sec. 4; and

(6) Communicate in writing with Participating Providers about the availability, scope of practice, and the type of THW services.

f. 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 on the CCO Contract Forms Website. Contractor shall provide its THW Integration and Utilization Report to OHA by November 15 of each Contract Year for the 12-month period ending on the immediately preceding June 30, along with Contractor's updated THW Integration and Utilization Plan. Data to be collected and documented in the THW Integration and Utilization Report shall include:

(1) An assessment of Member satisfaction with THW services;

(2) Ratio of OHA-certified THWs to the total number of Members;

(3) Number of 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;

(e) Patient Health Navigators; and

(f) Tribal Traditional Health Workers, provided that OARs relating to certification of Tribal THWs are in effect for some or all of the reporting period.[55]

(4) Whether each such THW is employed by Contractor or provides services under a Network Provider agreement 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 REALD;

(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.

[55] OHA expects the OARs for Tribal THW certification to be effective in early 2026.

(10) 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.

(11) 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.

12. REALD Data Collection

a. Contractor shall comply with the REALD data collection requirements set forth in Enrolled Oregon House Bill 3159 (2021) and as specified in OAR Chapter 950, Division 30. Whenever OHA adopts rules implementing HB 3159 for the collection of data on sexual orientation and gender identity, then all references to REALD data in this Contract are changed to "REALD & SOGI" and are interpreted to include sexual orientation and gender identity data.

b. Contractor shall ensure that all downstream contracts, including but not limited to those with Participating Providers and Subcontractors, that require the other party to collect and submit any Demographic Data to Contractor also require the other party to include REALD data in that data collection and submission.

[Remainder of page intentionally left blank]

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth

1. Overview of Solvency Plan

a. Terms used in this Ex. L are defined in OARs 410-141-5000, 410-141-5055, and 410-141-5195 and are incorporated by reference as though fully set forth in this Ex. 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 410-141-5380, 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 410-141-5240.

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.

(1) Contractor shall develop and maintain policies and procedures as described in OAR 410-141-5360 to ensure that, in the event of Contractor's insolvency, Members and related Clinical Records are transitioned to other CCOs or Providers with minimal disruption ("Insolvency Plan"). OHA will provide Contractor with a Guidance Document to assist in the development of its Insolvency Plan. Such Guidance Document is located on the CCO Contract Forms Website.

(2) Contractor shall submit its Insolvency Plan to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

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 using OHA's Secure File Transfer Protocol (SFTP) website, with its first quarterly report for each Contract Year and as may be requested from time to time. Contractor shall use Report L2 of the Exhibit L template (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. Financial Responsibility; Allowable Expenses and Costs

In keeping with Contractor's obligations under Sec. 1, Para. c above of this Ex. L, and in keeping with the State's goals, as set out in ORS 414.018, 414.570, and 442.386, which include, without limitation, (i)

increasing the quality, reliability, and continuity of care, (ii) ensuring the long-term affordability and financial sustainability of the State's health care system, and (iii) advancing the use of health information technology to achieve the foregoing goals as well as many others, Contractor must ensure all costs and expenses are necessary for Contractor's business operations and rationally related to serving the goals of the State.

a. Contractor shall ensure all annual executive and director level compensation (including fringe benefits), that is reported to OHA as an allowable administrative expense to be included in the development of capitation rates is (i) reasonable for the actual services rendered, (ii) conforms to the established, written policies of Contractor, and (iii) is not in excess of the benchmark compensation amount determined applicable for the fiscal year by the Office of Federal Procurement Policy adjusted annually to reflect the change in the Employment Cost Index for private industry workers in service producing industries as calculated by the Bureau of Labor Statistics. For purposes of this Para. a, "Compensation" means the total amount of wages, salary, bonuses, deferred compensation (including securities), and fringe benefits, whether paid, earned, or otherwise accruing during a calendar year. Fringe benefits include, without limitation, the costs of vacation, personal, and sick leave, insurance benefits (life, health, etc.), retirement benefits, and severance pay. In the event OHA determines Contractor has failed to report the compensation of its executives and directors in accordance with the criteria set forth in this Para. a, OHA shall have the right to determine the allowable reportable compensation that will be used in the development of capitation rates.

b. Contractor shall ensure all transactions (including, without limitation, those for management, professional, consulting, and other services, for real or personal property, equipment, supplies, and financing) that are reported to OHA as allowable expenses to be included in the development of capitation rates (i) are reasonably necessary for the operation of the CCO, (ii) comply with Contractor's established, written procurement policies and procedures, and (iii) do not impair or otherwise compromise (w) Contractor's obligation to provide Covered Services to its Members, (x) the ability of Contractor to recruit, retain, employ, or contract with sufficient numbers of Providers or health care practitioners (physical, behavioral, and oral health, THWs, etc.), or both, to achieve network adequacy in a manner that reflects and meets the needs of the diversity of populations within Contractor's Service Area, (y) the implementation and use of EHRs throughout its Provider Network as set forth in its HIT Roadmap, and (z) any other obligations of Contractor under this Contract.

(1) Except as provided in Sub.Para. (2) below of this Para. b, and in addition to the requirements set for in Para. b above of this Sec. 2, all transactions with, or payments to, a Related Party that are reported to OHA as allowable expenses to be included in the development of capitation rates must be valued at the Cost to the Related Party, not to exceed the Fair Market Value of comparable services, property, equipment, or supplies that could be purchased elsewhere and resulting from an arm's length transaction. However, if the Fair Market Value for comparable services, property, equipment or supplies is lower than the Costs of the Related Party, the allowable reported expense shall not exceed the Fair Market Value.

(2) Notwithstanding Sub.Para. (1) above of this Para. b, an exception may be provided if Contractor demonstrates by convincing evidence, as reasonably determined by OHA, that: (i) the service provider, supplier of equipment or supplies, property owner, or financing organization (individually and collectively, "Vendor") is a bona fide separate organization; (ii) a substantial part of the Vendor's business activity with Contractor is transacted with third-parties that are not related to the Vendor by common ownership or

control and there is an open, competitive market for the type of services, property, equipment, or supplies offered by the Vendor; (iii) the charge to Contractor by the Vendor is in line with the charge for the services, property, equipment, or supplies offered on the open market and is no more than the charge made under comparable circumstances to others by the Vendor for such services, property, equipment, or supplies. In such event, the charge by the Related Party to Contractor for such service, property, equipment, or supplies is allowable at Cost.

(3) In the event OHA determines Contractor has failed to report transactions in accordance with the criteria set forth in this Para. b, OHA shall have the right to determine the allowable reportable sums that will be used in the development of capitation rates.

(4) For the purpose of this Para. b, "Cost" means the expenditure required to create or sell services, property, equipment, or supplies, without any mark-up for profit.

(5) For the purpose of this Para. b, "Fair Market Value" means the price payable for comparable services, property, equipment, or supplies which could be purchased elsewhere, resulting from an arm's length transaction entered into by willing buyers and willing sellers, neither being under any compulsion to purchase or sell and both having reasonable knowledge of the facts.

c. Contractor shall include in each contract, agreement, and purchase order entered into with, and issued to, every Vendor the obligation to comply with any and all requests for information, records, and documents requested by Contactor (and identified by OHA) as may be necessary to be granted an exception under Sub.Para. (2) above of Para. b above of this Sec. 2.

d. Without limiting any other terms and conditions of this Contract, Contractor's failure to comply with its obligations under Paras. a through c above under this Sec. 2 shall be a material breach of this Contract.

3. 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.

(2) Contractor shall truthfully respond, and shall cause all of its officers, employees, Agents, and Subcontractors to 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. Contractor shall comply with the requests of OHA or DCBS or both under OAR 410-141-5245 and OAR 410-141-5250.

(4) Contractor shall file all NAIC A-D and F Forms as required under the rule and if such conditions exist that require such Forms to be submitted. All such forms shall also be submitted to OHA, via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website.

(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. OHA or DCBS or both may engage third parties to conduct reviews or perform examinations of Contractor. Contractor is responsible for the cost such third parties engaged by OHA or DCBS or both.

(6) All requests for information and documentation made under this Para. a, regardless of whether the request is made by OHA, DCBS, or their authorized representatives or agents, shall be responded to by Contractor within seven (7) Business days after the date of such request. Notwithstanding the foregoing, Contractor may request that OHA or, as applicable, DCBS, provide Contractor with additional time to respond to any request for information or documentation. Any such extension of time granted shall be subject to OHA's, or as applicable, DCBS' reasonable discretion.

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 Ex. 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.

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 nine ending on December 31, 2028, survives termination of this Contract and Contractor shall submit such annual financial statements in accordance with this Para. c, Sec. 3, Ex. L to OHA no later than April 30, 2029.

(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 410-141-5200.

(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 (MD&A) prepared in accordance with the NAIC Forms and Instructions.

(a) Contractor shall identify in the MD&A any Sanction(s) imposed by OHA under this Contract within the two immediately preceding Contract Years. Contractor shall describe each specific Sanction and the violation that resulted in the Sanction.

d. Quarterly Financial Statements

Contractor shall submit to OHA, via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website, 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,[56] 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 using OHA's Secure File Transfer Protocol (SFTP) website. 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 nine ending on December 31, 2028, survives termination of this Contract, and Contractor shall submit such annual audited financial statement in accordance with this Para. j, Sec. 3, Ex. L to OHA no later than June 30, 2029.

(2) There shall be an exception to materiality for substantive testing for Flexible Services and SHARE expenditures reported annually by Contractor. Contractor shall disclose any exceptions found during the course of substantive testing as part of the financial audit process in the audit management letter.

4. 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 using OHA's Secure File Transfer Protocol (SFTP) website.

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.

[56] This existing OAR will be updated effective 1/1/2026.

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, semi-annually, or annually, along with the respective due dates.

d. Contractor shall submit the completed supplemental reports to OHA via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website.

5. Other Required Reports

a. Contractor shall submit its Corporate Governance Annual Disclosure (CGAD) Report to OHA, via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website, 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, Affiliates, 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 410-141-5295 and 410-141-5300). 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 410-141-5300) and Form F filing (OAR 410-141-5330) at the same time as its Form B registration. Form B, Form C, and Form F must be submitted via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website.

d. Contractor shall submit filings related to, and necessary for securing the Authority's approval of transactions within Contractor's holding company (OAR 410-141-5320).

e. Contractor shall apply for approval of extraordinary dividends and distributions (OAR 410-141-5225). If prior approval of a dividend or distribution is not required (OAR 410-141-5180), 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. Required Forms and Instructions regarding dividends and distributions are available on the CCO Contract Forms Website and should be completed and submitted to OHA using OHA's Secure File Transfer Protocol (SFTP) website.

6. 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. 6 limits Contractor, OHA, a Provider or Subcontractor from pursuing other legal remedies that will not result in Member personal liability for such payments.

7. 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 410-141-5185. 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, quarterly in conjunction with the submission of the Ex. L Financial Reporting Template, via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website, an account statement for its Restricted Reserve Account. Such account statement shall be submitted by Contractor at the same time as Contractor submits its quarterly financial statement to OHA.

(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 410-141-5185, OHA will provide written Legal Notice to Contractor in accordance with Ex. D, Sec. 25.

(3) Within thirty (30) days of Contractor's receipt of any Legal Notice by OHA under this Sec. 6, 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 using OHA's Secure File Transfer Protocol (SFTP) website, 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.

8. 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 410-141-5200).

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 410-141-5205 through 410-141-5220, 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 410-141-5170). OHA will provide written Legal Notice to Contractor of its determination(s) under this Para. c in accordance with Ex. D, Sec. 25.

(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.

9. 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.

c. In accordance with Enrolled Oregon House Bill 2081 (2021), if Contractor does not achieve the sustainable growth target, OHA may require a Corrective Action Plan and may impose Sanctions. Sanctions may include reductions to quality pool, other performance-based incentive payments, or civil penalties as may be set forth in any administrative rules adopted by OHA in accordance with HB 2081 (2021).

10. Delivery of Reports, Information, and Documents to OHA

a. Contractor shall submit all Reports required to be delivered to OHA under this Ex. L via Administrative Notice using OHA's Secure File Transfer Protocol (SFTP) website.

b. OHA shall require some Reports to be submitted under this Ex. 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.

c. Except as may otherwise be provided for under Applicable Law, all requests for information and documentation made by OHA's Office of Actuarial and Financial Analytics, DCBS, or their authorized representatives or agents, shall be responded to by Contractor within seven (7) Business days after the date of such request. Notwithstanding the foregoing, Contractor may request that OHA or, as applicable, DCBS, provide Contractor with additional time to respond to any request for information or documentation. Any such extension of time granted shall be subject to OHA's, or as applicable, DCBS' reasonable discretion.

[Remainder of page intentionally left blank]

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://archive.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, including Mental Health wellness appointments as specified in the applicable OARs implementing Enrolled Oregon House Bill 2469 (2021), 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 conditions of this Contract, including without limitation Ex. B, Part 4.

d. Arrange for the provision of Flexible 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 enter into Network Provider agreements with Behavioral Health Providers to meet its obligations under this Sec. 1, Ex. M and any and all other applicable provisions of this Contract relating to the provision of Behavioral Health services. Contractor shall enter into Network Provider agreements 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 each and every one of its obligations under this Sec. 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 Behavioral 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.

h. As required by Enrolled Oregon House Bill 3046 (2021), provide Behavioral Health services that include but are not limited to:

(1) For a Member who is experiencing a Behavioral Health crisis, a Behavioral Health assessment and services that are Medically Necessary to transition the Member to a lower level of care;

(2) At least the minimum level of services that are Medically Necessary to treat a Member's underlying Behavioral Health condition rather than a mere amelioration of current symptoms, such as suicidal ideation or psychosis, as determined in a Behavioral Health assessment of the Member or specified in the Member's care plan;

(3) Treatment of co-occurring Behavioral Health disorders or medical conditions in a coordinated manner;

(4) Treatment at the least intensive and least restrictive level of care that is safe and effective and meets the needs of the Member's condition;

(5) For all level of care placement decisions, placement at the level of care consistent with a Member's score or assessment using the relevant level of care placement criteria and guidelines;

(a) If there is a disagreement about the level of care required by Ex. M, Sec. 1, Para. h., Sub.Para. (5) or (6), Contractor shall provide to the Behavioral Health treatment Provider full details of Contractor's scoring or assessment, to the extent permitted by HIPAA and other Applicable Laws limiting the disclosure of health information.

(6) If the level of placement described in Ex. M, Sec. 1, Para. h, Sub.Para. (5) is not available, placement at the next higher level of care;

(7) Treatment to maintain functioning or prevent deterioration;

(8) Treatment for an appropriate duration based on the Member's particular needs;

(9) Treatment appropriate to the unique needs of children and adolescents;

(10) Treatment appropriate to the unique needs of older adults;

(11) Treatment that is Culturally and Linguistically Appropriate;

(12) Treatment that is appropriate to the unique needs of gay, lesbian, bisexual, and transgender Members and Members of any other minoritized gender identity or sexual orientation; and

(13) Coordinated care and case management as specified in this Contract and the applicable OARs.

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. Contractor shall reimburse Providers for treatment of Members with Co-Occurring Disorders as described in Section 2 of Enrolled Oregon House Bill 2086 (2021) and as specified in the applicable OARs.

f. 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 as described in OAR 309-019-0135 for services billed by the same Behavioral Health Provider and provided in an outpatient setting.

g. Contractor may enter into Value Based Payment arrangements with Behavioral Health Providers, as permitted under Ex. H of this Contract.

h. Contractor shall cover and reimburse inpatient mental health services, except when those services are provided at an Institution for Mental Diseases (IMD). OHA may, however, make a monthly capitation payment to a Contractor using Medicaid capitated funds for inpatient mental health services provided at an IMD as an alternative setting to those covered under the State Plan, when all of the following requirements are met in accordance with 42 CFR § 438.6(e):

(1) The Member receiving services is aged 21-64;

(2) The services are provided for a short-term of no more than 15 days during the period of the monthly capitation payment; and

(3) The provision of services at the IMD meets the requirements for In Lieu of Services (ILOS) as set forth in Ex. B, Part 2, Sec. 11.

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 living in the most integrated setting appropriate for the Member.

d. Ensure that Members transitioning to another health care setting are receiving services 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, staff in carceral settings (i.e., state or federal prisons, local correctional facilities, juvenile detention facilities, Tribal correctional facilities), community corrections, 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, admissions to carceral settings,

lengths of stay in carceral settings, and recidivism along with improvements in stability of employment and housing.

g. Work with Providers of physical health and Behavioral Health services in the carceral setting (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 carceral settings. 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 develop and maintain written policies and procedures for Behavioral Health services ("BH P&Ps") that comply with the requirements of this Contract and Applicable Laws. Contractor shall submit its BH P&Ps to OHA within five (5) Business Days of the request and in the manner and to the location identified by OHA in the request.

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. Refrain from requiring Prior Authorization for certain Behavioral Health services within Contractor's Provider Network as specified in OAR 410-141-3835. Contractor shall require Prior Authorization for the Behavioral Health services identified in Ex. B, Part 2, Sec. 3, Para. b, Sub.Para. (6) and as may be specified elsewhere in this Contract.

c. Refrain from requiring, as set forth in OAR 410-141-3835, Members to obtain Prior Authorization for Medication Assisted Treatment (**"MAT"**). However, Contractor may, but is not obligated to, require Members to obtain Prior Authorization for MAT as otherwise permitted under OAR 410-141-3835.

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 Mental Health hospitalization or residential care and, consistent with OAR 410-141-3835, within two (2) Business Days for non-emergent SUD services.

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 deny a Member access to mental health assessment, treatment, or services on the basis that the Member also has an intellectual or developmental disability, consistent with Section 1 of Enrolled Oregon Senate Bill 729 (2025).

h. Not apply more stringent utilization or Prior Authorization standards to Behavioral Health services, than standards that are applied to medical/surgical benefits.

i. 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.

j. Ensure Contractor's staff, including those of any Subcontractor delegated such responsibility, making Prior Authorization determinations for Substance Use Disorder treatment services and supports have adequate training and experience to evaluate medical necessity for Substance Use Disorders using the ASAM Criteria and DSM criteria.

k. Consistent with Section 10 of Enrolled Oregon Senate Bill 1529 (2022), Contractor does not have the right to require Prior Authorization for specialty Behavioral Health services provided in a PCPCH unless permitted by OHA in any applicable OARs that may be adopted in the future.

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.

7. Substance Use Disorders

Contractor shall:

a. Provide SUD services to Members, which include crisis intervention, outreach and engagement, case management, care coordination, 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. SUD services also include Community Integration Services as described in the OHP SUD 1115 Demonstration Waiver approved by CMS and as specified in applicable OARs.

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 ASAM Criteria for:

(1) Outpatient, intensive Outpatient, SUD Day Treatment, residential, Withdrawal Management, 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: court referrals, Child Welfare referrals; employment, education, housing support services or Referrals; and services or Referrals to specialty treatment 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) Children and adolescents, taking into consideration child and adolescent development and Co-Occurring Disorders,

(2) Individuals who identify as LGBTQIA2S+,

(3) Women, and women's specific issues,

(4) Ethnically and racially diverse groups,

(5) Intravenous drug users,

(6) Individuals involved with the criminal justice system,

(7) Individuals with Co-Occurring Disorders,

(8) Parents accessing residential treatment with any accompanying dependent children,

(9) Veterans and military service members, and

(10) Individuals accessing residential treatment with Medication Assisted Treatment.

f. Provide withdrawal management services at the most Medically Appropriate level of care. Withdrawal management settings include outpatient ambulatory, residential, and inpatient. Non-Hospital based facilities or programs providing withdrawal management services at ASAM Levels 3-WM through 3.7-WM must have a license from OHA in accordance with OAR Chapter 415, Division 12 and follow the program standards specified in OAR Chapter 415, Division 50.

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.

i. Comply with the requirements relating to Behavioral Health Resource Networks as specified in the applicable OARs.

j. Require all staff (including staff of any Subcontractor(s)) making Prior Authorization (PA) determinations for SUD treatment services and supports have a working knowledge of the ASAM Criteria, as required by the OHP SUD 1115 Demonstration waiver. Contractor shall submit to OHA, via Administrative Notice, by July 31 of each Contract Year an Attestation of its compliance with this requirement. Contractor shall also provide to OHA, via Administrative Notice, the information that is the basis of its Attestation within five (5) Business Days of request by OHA. Such information may include but is not limited to staff training, experience, continuing education, and credentials specific to the ASAM Criteria. Without limiting any other rights and remedies OHA may have under this Contract, OHA has the right, in accordance with Ex. B, Part 9, to impose one or more Sanction(s) if it determines that Contractor's Attestation is false.

8. Co-Occurring Disorders

Contractor shall ensure access to treatment for Co-Occurring Disorders (COD) for Members assessed at Levels 1 or 2 of the ASAM Criteria with Providers approved by OHA for COD services, contingent upon the availability of one or more appropriately approved COD Providers in Contractor's Service Area. Contractor shall ensure access to treatment for COD for Members assessed at Levels 3 or 4 of the ASAM Criteria with Providers approved or licensed by OHA for COD services, contingent upon the availability of one or more appropriately approved or licensed Providers and regardless of whether the Provider is located in Contractor's Service Area.

9. Gambling Disorders

Contractor shall ensure Member access to Outpatient Problem Gambling Treatment Services that are Medically Necessary Covered Services, contingent upon the availability of Providers certified by OHA for such services in Contractor's Service Area. Contractor shall assist its Members in gaining access to problem gambling treatment services not covered by this Contract, including, but not limited to, residential treatment and Outpatient treatment that do not meet DSM diagnostic criteria for a gambling disorder. Such services are Carve-Out Services and paid by OHA under its direct contracts with Providers.

10. Assertive Community Treatment

a. Contractor shall ensure a Member receives a face-to-face discussion regarding ACT services that includes providing informational resources that will support the Member in making an informed decision regarding their 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 a 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 ACT service denials, which include but are not limited to a Member being waitlisted or receiving a lower level of care for more than thirty (30) days, are:

(1) Based on the ACT Evidence-Based medical necessity criteria and cite the applicable content in OAR 309-019-0250 or the medical necessity criteria based on the clinical evaluation;

(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. 10 of Ex. M within five (5) Business Days of request by OHA.

11. Peer Delivered Services and Outpatient Behavioral Health Services

a. 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), Wraparound, behavior supports, crisis care, Respite Care, 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.

12. 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, Mobile Crisis Intervention Services, Stabilization 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 Services, Mobile Crisis Intervention Services, Stabilization Services, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.

d. Contractor shall ensure access to Mobile Crisis Services, Mobile Crisis Intervention Services, and crisis hotline for all Members, and Stabilization Services for children and their families, in accordance with OAR 309-019-0150, Chapter 309, Division 72, 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.

13. Care Coordination

a. Contractor shall provide Care Coordination for Members with Behavioral Health disorders in accordance with OARs 410-141-3860, 410-141-3865, and410-141-3870 and the applicable sections in Ex. B, Parts 2 and 4 of this Contract.

b. Contractor shall ensure all entities primarily responsible for providing Care Coordination services work with Provider team members to coordinate integrated care with entities identified in OAR 410-141-3860(2).

c. Contractor shall ensure coordination and appropriate Referral to ensure that Member's rights are met and there is post-discharge support.

14. Community Partner Engagement

a. Contractor shall enter into and maintain a written agreement with the Local Mental Health Authority(ies) 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 to coordinate and collaborate on the development of Contractor's Community Health Improvement Plan with the LMHA(s) and CMHP(s) for the delivery of mental health services in accordance with ORS 430.630.

15. Oregon State Hospital

a. Contractor shall be financially responsible for Members on the waitlist for OSH.

b. 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.

c. 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.

d. 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.

16. 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 a 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 repeated use of Emergency Departments for Behavioral Health reasons.

17. 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 only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-07403.

c. Contractor shall coordinate with the CMHP Director in Contractor's Service Area in assuring that all treatment requirements are met. Contractor shall work with the CMHP Director in assigning a civilly committed Member to any placement.

d. Contractor shall, in coordination with the CMHP Director or their delegate, 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.

18. Long Term Psychiatric Care

a. 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. 18, 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 coordinating care for Members who are being admitted, discharged, or transitioned (or all or any combination thereof) from LTPC 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.

b. For a Member age seventeen (17) or younger:

(1) If Contractor identifies a Member age seventeen (17) or younger who is appropriate for a LTPC Referral, Contractor shall request a LTPC determination by following the process described in Procedure for LTPC Determinations for Members 17 and Under, available on the CCO Contract Forms Website;

(2) OHA will respond to Contractor no more than three (3) Business Days following the date OHA receives a completed Request for LTPC Determination for Member 17 and Under.

(3) Contractor shall work with OHA to coordinate Member admissions and discharges to LTPC Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP).

(4) Contractor shall ensure that utilization of LTPC is reserved for the most Acute and complex cases by providing pre-application review and confirmation of meeting criteria and only for the period of time necessary and Medically Appropriate to remediate symptoms that led to admission. Contractor shall provide Care Coordination throughout the length of stay at LTPC and support treatment and Community Provider teams with transition planning, although Contractor is ultimately responsible for transition and discharge planning as specified in Sub.Para. (5)(c) below of this Sec. 18, Ex. M.

(5) The Member will remain enrolled with Contractor for delivery of SCIP and SAIP services. Contractor shall be responsible for:

(a) Care Coordination or Fidelity Wraparound for the entire length of stay, including admission determination and planning;

(b) Monitoring services provided by the LTPC Provider and coordinating additional supports as necessary;

(c) Transition and discharge planning; and

(d) Ensuring the Member has access to a Child and Family Team and Intensive In-home Behavioral Health Treatment (IIBHT) or Community Provider(s) as recommended by the LTPC Provider. This should include collaborative relationships with all system partners to achieve Continuity of Care.

(6) Contractor shall coordinate with the LTPC Provider's clinical team, the Member and the parent or guardian of the Member, and Community Providers to assure timely discharge and transition from the LTPC facility to the most appropriate, independent, and integrated community-based setting possible.

19. 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. 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.

d. 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.

e. 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.

f. Contractor shall ensure that adult Members receive a follow-up visit with a Community Behavioral Health Provider after discharge from an Acute Care Psychiatric Hospital as follows:

(1) Within seven (7) days after discharge for all Members, except those identified in Sub.Para. (2) below.

(2) Within three (3) days after discharge for a Member who is likely, in the reasonable opinion of the provider discharging the Member from the Acute Care Psychiatric Hospital, to experience a negative health outcome if the seven (7) day follow-up visit requirement specified in Sub.Para. (1) above is applied to them.

g. 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.

h. 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.

20. Pregnant Individuals' 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 individuals receive immediate intake and assessment in accordance with timely access standards in OAR 410-141-3515.

21. 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, if clinically indicated, a psychological evaluation current within the past twelve (12) months and will 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 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 ODHS Child Welfare or Oregon Youth Authority (OYA). For a Member seventeen (17) and under, placed by ODHS Child Welfare through a voluntary placement agreement (CF 0499), Contractor shall also coordinate with such Member's parent or legal guardian.

h. Contractor shall develop and maintain written policies and procedures relating to the use of psychotropic drugs for children, especially those in the custody of ODHS, in accordance with Para. d, Sec. 7, Ex. B, Part 2 of this Contract.

i. Contractor shall ensure that admission to PRTS is in accordance with Certificate of Need process described in OAR 410-172-0690.

j. Contractor shall ensure that level of care criteria for Behavioral Health Outpatient services, Intensive Outpatient Services and Supports, and IIBHT 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.

k. 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.

l. Wraparound Supports: Contractor shall provide Wraparound supports to eligible Members in accordance with OAR 309-019-0162 and 309-019-0163, 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 (P&Ps) 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 Wraparound, 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 Wraparound supports to be placed on a waitlist.

(b) No Member on a waitlist for Wraparound may be without such services for more than fourteen (14) days.

m. Contractor shall submit its Wraparound P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

n. 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[57] 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 309-019-0163.

(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.

[57] As stated in OAR 410-151-0000, EPSDT rules take precedence over all other rules in OAR Chapters 410 and 309 as they relate to OHP services for individuals under age 21. For this reason, Wraparound must be provided to individuals through age 20, regardless of the references in OAR Chapter 309, Division 19 to Wraparound as a program for individuals under age 18.

(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 309-019-0163(15); (ii) in connection with receipt of Wraparound Fidelity Tool Index Tool (WFIEZ) used by OHA; (iii) once per biennium; and (iv) 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 309-019-0163(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.

o. 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, Contractor may combine its Practice Level Workgroup with its Advisory Committee, or with its Executive Council, or with both its Advisory Committee and Executive Council. Contractor shall work with any and all other CCOs 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 and maintain SOC policies and procedures (P&Ps) that address the components listed below. Contractor's SOC policies and procedures shall be approved by its SOC Executive Council.

(a) How Contractor meaningfully supports the leadership and involvement of youth and families at all levels of the SOC governance structure.

(b) 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.

(c) How Contractor supports the inclusion and collaboration of Community partners and system partners to ensure youth and families have access to necessary supports and services.

(4) Contractor shall submit its SOC P&Ps to OHA within five (5) Business Days of OHA's request and in the manner and to the location identified by OHA in the request.

(5) Contractor shall submit bi-annual reports related to barriers for the System of Care Advisory Council - State Agency Standing Committee to OHA, via Administrative Notice, within thirty (30) days after the end of each six-month period. Contractor shall use the template provided by OHA on the CCO Contract Forms Website.

p. 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 that the CANS data for each Member enrolled in Fidelity Wraparound is entered into the online data system designated by OHA. OHA will provide Contractor with information on use of the system.

22. 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) If Contractor lacks Provider capacity to provide IIBHT services, Contractor shall immediately notify OHA, via Administrative Notice, and develop and submit within seven (7) Business Days, via Administrative Notice, a plan to increase Provider capacity within sixty (60) days ("60-Day Plan").

(a) Lack of capacity is not a basis for putting Members who are eligible for IIBHT on a waitlist.

(b) No Member eligible for IIBHT services may be without such services for more than fourteen (14) days.

(c) Contractor shall submit a progress report for its 60-Day Plan to OHA, via Administrative Notice, every thirty (30) days. If Contractor has not, as determined by OHA in its reasonable discretion, made sufficient progress to increase Provider capacity, OHA may, but is not required, to extend the duration of the 60-Day Plan and require Contractor to continue to submit progress reports every thirty (30) days until OHA has determined, in its reasonable discretion, that Contractor is making sustainable progress toward meeting Provider capacity. OHA reserves the right to impose one or more Sanctions as described Ex. B, Pt. 9 if, at the conclusion of the sixty (60) days of the 60-Day Plan, Contractor continues to lack capacity to provide IIBHT services.

(2) Contractor shall maintain sufficient funding and resources to implement the IIBHT program for Members twenty (20) years and younger for any Member meeting entry criteria.

(3) Contractor shall make culturally and linguistically appropriate information about IIBHT easily available and accessible on Contractor's website where other information about Member benefits is provided. At a minimum, the IIBHT information on Contractor's website must provide a brief description of IIBHT, explain how Members can access IIBHT, and provide the contact information for Contractor's Participating Providers for IIBHT.

~~**(4)** Contractor shall submit to OHA, via Administrative Notice, bi-annual reports about IIBHT referrals and enrollments with each of Contractor's Participating Providers. Each report is due within thirty (30) days after the end of each six-month period. Contractor shall use the reporting template provided by OHA on the CCO Contract Forms Website.~~

23. Reporting Requirements

a. Contractor shall report Behavioral Health cost and utilization data in accordance with Exhibit L Financial Report Template.

b. Contractor shall ensure that its Subcontractors and Participating Providers supply all required information to support the reporting process described in this Sec. 23.

c. Contractor shall ensure that all Behavioral Health Providers with a Certificate of Approval or a license from OHA enroll Contractor's Members in OHA's Measures and Outcomes Tracking System (MOTS) and in the data system designated by OHA to replace MOTS. Details about such Provider reporting are located at the following website: https://www.oregon.gov/oha/HSD/COMPASS/Pages/index.aspx.

24. Providers

a. Contractor shall ensure Contractor's employees, Subcontractors, and Providers are trained in integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/resources/training/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 (ACEs), trauma and resiliency in a Culturally and Linguistically Appropriate manner, using a Trauma Informed framework.

d. Contractor shall ensure that employees or Providers who assess Members for admission to, and length of stay in, Substance Use Disorders and Co-Occurring Disorders programs and services use the ASAM Criteria for level of care placement decisions, and that they have the training and background necessary to evaluate medical necessity for Substance Use Disorders Services using the ASAM Criteria and DSM criteria.

e. 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.

f. 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.

25. Mental Health Parity Reporting Requirements

a. Contractor shall participate in an annual Mental Health (MH) Parity analysis 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, Enrolled Oregon House Bill 3046 (2021), and Sec. 22 of Ex. E of this Contract regarding parity in mental health and SUD benefits. OHA shall review Contractor's MH Parity analysis documentation to confirm that any limitations (such as Aggregate lifetime and annual dollar limits, Financial requirements, Treatment limitations, Quantitative treatment limitations, or Non-quantitative treatment limitations) that Contractor may have imposed on accessing mental health and SUD services, in any classification of benefits, are not substantially different from, or more limiting than, those for medical or surgical benefits.

b. Contractor shall submit the documentation specified in the MH Parity evaluation criteria or Guidance Document (or both) to OHA, via Administrative Notice, according to the schedule specified in Sub.Paras. (1-2) below of this Para. b. OHA will provide the evaluation criteria,

Guidance Document, and required reporting template on the CCO Contract Forms Website. If no changes have been made to Contractor's MH Parity analysis documentation for areas deemed compliant since it was last provided to OHA, Contractor may submit to OHA, via Administrative Notice, an Attestation stating that no changes have been made. Contractor shall provide its MH Parity analysis documentation to OHA as follows:

(1) Annually by no later than June 1 of 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 NQTLs are consistent with 42 CFR Part 438, Subpart K and Sec. 22 of Ex. E of this Contract. Further, Contractor must demonstrate in the documentation submitted under Ex. M, Sec. 25, Para. a. that the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to Behavioral Health Coverage, as written and in operation, are comparable to and are applied no more stringently that the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to medical or surgical treatments in the same classification. 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. 25, Ex. M, Contractor shall follow the process set forth in Ex. D, Sec. 5 to this Contract.

d. Using the format provided by OHA, Contractor shall provide the information necessary for OHA to conduct the annual assessment required by HB 3046 (2021), the results of which will be utilized in a report due to the Legislature by December 31 of each year. This report will also include OHA's findings on MH Parity compliance by CCOs including Contractor and by the Fee-for-Service program operated by OHA. The annual assessment will cover:

(1) The adequacy of CCOs' Provider Networks as prescribed by rule;

(2) The timeliness of Member access to Behavioral Health Coverage, as prescribed by rule;

(3) The criteria used by Contractor to determine medical necessity and Behavioral Health Coverage, including Contractor's payment protocols and procedures;

(4) Data on services that are requested but that Contractor is not required to provide;

(5) The consistency of credentialing requirements for Behavioral Health treatment Providers with the credentialing of medical and surgical treatment providers; and

(6) UR applied to Behavioral Health Coverage compared to coverage of medical and surgical treatments.

[Remainder of page intentionally left blank]

Exhibit N – Privacy and Security

1. Purpose

Contractor requires the Access described in the OHA-ODHS form titled "Third Party Information System Access Request" (Form MSC 0785), which is hereby incorporated into this Ex. N by reference, to perform the Work. The terms and conditions of this Ex. N govern:

a. Contractor's Use of Data;

b. Contractor's Access to OHA's Information Assets and Systems; and

c. The periodic exchange of Data between OHA's and Contractor's systems via electronic means.

2. Definitions

The following definitions apply to this Ex. N:

a. "Access" means the ability or the means necessary to read, communicate, or otherwise use OHA or State Data, Network and Information Systems, and Information Assets.

b. "Breach" means the acquisition, access, exposure, use, or disclosure of Data or an Information Asset in a manner not in compliance with Applicable Law, rule, policy, or contract, or Data loss, misuse, or compromise.

c. "Client Records" includes any Client, applicant, or Member information, including, without limitation, personally identifiable information, medical records and other related records, regardless of the media or source, collected by Contractor in the course of completing the Work, provided through the Network and Information Systems to Contractor, or otherwise exchanged between the parties.

d. "Data" means information created, transmitted, or stored through the Network and Information Systems, including metadata, personal information, and Client Records.

e. "Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of any Network and Information System or Information Asset. An Incident is an observable, measurable occurrence that is a deviation from expected operations or activities. An Incident may be a Breach, failure to protect a User's identification (ID), or theft of computer equipment that uses or stores any Information Asset.

f. "Individual Access Request (IAR)" refers to the OHA form used to authorize a User, identify the User's job assignment, and the required access to Network and Information System(s). It generates a unique alpha/numeric code used to access the OHA Network and Information Systems.

g. "Information Asset(s)" refers to all information provided through OHA, regardless of the source, which requires measures for security and privacy. Includes Data.

h. "Information Security and Privacy Office" and "ISPO" each refers to the OHA office that manages privacy, security, awareness and education, e-discovery, information exchange, and risk management for OHA and ODHS programs.

i. "Network and Information System(s)" means OHA'S and the State of Oregon's computer infrastructure which provides personal communications; Data such as Client Records; Access to other Information Assets, regional, wide area, and local networks; and the internetworking of various types of networks.

j. "User" means any individual authorized to access Network and Information Systems and who has an been assigned a unique log-on identifier.

3. Changes to Form MSC 0785

a. **Point of Contact Changes**. Each party will provide Administrative Notice to the other of any change of its respective point(s) of contact noted in Form MSC 0785, including any technical lead, and name an interim or replacement person in any such notice. Upon such notification by either party or both parties, Form MSC 0785 will be deemed amended to include the updated information.

b. **Administrative Changes.** Contractor may request updates to Form MSC 0785 that are administrative in nature and do not modify the mode of Access or type of data by submitting a written request to ISPO. Upon Administrative Notice to Contractor's Designee of ISPO's acceptance of the updates, Form MSC 0785 will be deemed amended to include the updated information.

4. Notifications

a. **Points of Contact.** The parties will designate their respective technical leads in Form MSC 0785. The parties will facilitate direct contacts between technical leads. The parties will provide Administrative Notice to the other of any changes in technical point of contact information.

b. **Breach Notification.** In the event Contractor or its Subcontractors or Agents discover or are notified of an Incident or a Breach, including a failure to comply with Contractor's confidentiality obligations under this Contract, within one (1) Business Day of discovery or notification of the Incident or Breach. Contractor shall provide Administrative Notice to ISPO's Privacy Compliance Officer at DHS.PrivacyHelp@odhsoha.oregon.gov of the Incident or Breach, with a follow-up telephone call to ISPO's Privacy Reporting Line at 503-945-5780. If ISPO determines that an Incident or Breach requires notification of OHA clients, or other notification required by law, the ISPO will have sole control over the notification content, timing, and method, subject to Contractor's obligations under Applicable Law.

c. **Requests for Data.** In the event Contractor receives a third-party request for Data, including any electronic discovery, litigation hold, or discovery searches, Contractor shall first give ISPO notice and provide such information as may be reasonably necessary to enable OHA to protect its interests.

d. **Changes.** Each party will provide notice to the other of any change or development, which may significantly affect its ability to perform its obligations.

5. Grant of License

Subject to Contractor's compliance with this Contract, Contractor is hereby granted a non-exclusive, non-transferable, and revocable authorization to Access and use Information Assets only in accordance with this Ex. N and Applicable Law(s) and State policies. Contractor and its employees, Subcontractors, and Agents shall not manipulate any URL or modify, publish, transmit, reverse engineer, participate in any unauthorized transfer or sale of, create derivative works of, or in any way exploit the content or software comprising this Access, or Information Assets made available through this Access.

6. Data Privacy

In addition to Contractor's obligations regarding Confidentiality of Information:

a. **Generally.** Contractor shall hold all Client Records, and other information as to personal facts and circumstances obtained by Contractor on OHA Clients, as confidential, using the highest

standard of care applicable to the Client Records, and shall not divulge any Client Records without the written consent of the Client, the Client's attorney, the responsible parent of a minor child, or the minor child's guardian except as required by other terms of this Ex. N or Applicable Law(s).

b. **Limited Purposes.** Contractor shall limit the use or disclosure of Data concerning Clients to persons directly connected with the administration of this Ex. N or the Contract. Confidentiality policies apply to all requests from outside sources.

c. **Privacy Protections.** Data may include information, such as Client Records, subject to specified confidentiality protections under State or federal law. Contractor shall comply with all Applicable Law(s) and policies applicable to the information described in Form MSC 0785, including as specified in this Contract.

d. **Training.** Contractor's employees, Subcontractors, and Agents who will Access Data must have received training on the privacy and security obligations relating to the Data, including Client Records. Contractor shall provide periodic privacy and security training to its employees, Subcontractors, and Agents.

7. Security Requirements

a. **Compliance with Applicable Laws and Policies.** Contractor and its employees, Subcontractors, and Agents shall comply with all Applicable Laws and State policies governing use and disclosure of Data (including Client Records) and Access to Information Assets, including as those laws, regulations, and policies may be updated from time to time. Applicable Laws and State policies include but are not limited to:

(1) ODHS and OHA Information Security and Privacy Policies: https://www.oregon.gov/oha/FOD/OIS-ISPO/Pages/Policies.aspx

(2) ODHS and OHA Privacy and Confidentiality administrative rules, OAR Chapter 407, Division 14, and OAR Chapter 943, Division 14.

(3) Those referenced in this Ex. N or in Ex. E, "Required Federal Terms and Conditions, Sec. 6, "HIPAA Compliance".

(4) The Oregon Consumer Information Protection Act, ORS 646A.600 through 646A.628, to the extent applicable.

(5) Statewide Information Technology (IT) Control Standards:

https://www.oregon.gov/eis/cyber-security-services/Documents/eis-css-statewide-information-technology(IT)-control-standards.pdf.

(6) Oregon's Statewide Information Security Plan:

https://www.oregon.gov/eis/cyber-security-services/documents/statewideinformationsecurityplan.pdf.

(7) Oregon's Statewide Policies: https://www.oregon.gov/das/Pages/policies.aspx#IT.

(8) Security controls that meet or exceed "Moderate" security controls in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53.

b. **Responsible for Compliance.** Contractor is responsible for the compliance of its employees, Subcontractors, and Agents with this Ex. N and with any third-party licenses to which Access is subject.

c. **Privacy and Security Measures.** Contractor represents and warrants it has established and will maintain privacy and security measures that meet or exceed the standards set in Applicable Laws for the safeguarding, security, and privacy of Data, including Client Records, all Information Assets, regardless of the media, and all Network and Information Systems. Contractor shall monitor, periodically assess, and update its security controls and risk to ensure continued effectiveness of those controls.

d. **Security Risk Management Plan.** Contractor shall ensure the level of security and privacy protection required in accordance with this Ex. N is documented in a security risk management plan. Contractor shall make its security risk management plan available to OHA for review upon request.

e. **Audit Rights and Access.** Contractor shall maintain records in such a manner as to clearly document its compliance with and performance under this Ex. N, and provide OHA, the Oregon Secretary of State, the federal government, and their duly authorized representatives access to Contractor's officers, employees, Subcontractors, Agents, facilities and records for OHA to:

(1) Determine Contractor's compliance with this Ex. N,

(2) Validate Contractor's written security risk management plan, or

(3) Gather or verify any additional information OHA may require to meet any State or federal laws, rules, or orders regarding Information Assets.

f. Access to facilities, systems, and records under this Ex. N, Sec. 7 will be granted following reasonable notice to Contractor. Records include paper or electronic form, system security logs, and related system components and tools (including hardware and software), required to perform examinations and audits, and to make excerpts and transcripts, including for data forensics.

8. Access to OHA Systems

a. **OHA Review of User Requests.** If required for Access, OHA will review requests, including forms such as the Individual Access Request ("IAR"), and will:

(1) Notify Contractor of the approval or denial of its request for each User for whom Access has been requested;

(2) Provide any unique log-on identifier required for authorized Access;

(3) Provide updates to approved inquiry processes and instructions to Contractor.

b. **Contractor's Responsibilities for User Accounts**. Contractor shall facilitate completion of any forms (such as the IAR) for each employee for whom Access is requested.

(1) Contractor is responsible for all activities that occur through its Access, including for any acts related to a lost or stolen User ID or password.

(2) Contractor is responsible for ensuring information provided by its Users is accurate, complete, and up to date.

(3) Contractor shall immediately notify OHA when a User, group of Users, or Contractor, no longer requires Access whether due to changes in duties or due to changes in Contractor's programs related to this Contract.

c. **Security and Disposal.** Contractor shall maintain security of equipment, and ensure the proper handling, storage and disposal of all Information Assets accessed, obtained, or reproduced by Contractor and its Users to prevent inadvertent destruction or loss. Contractor shall ensure proper disposal of equipment and Information Assets when authorized use ends, consistent with

Contractor's record retention obligations and obligations regarding Information Assets under this Contract.

d. **Prevention of Unauthorized Access.** Contractor shall prevent any Access to State of Oregon Network and Information Systems by its Users that is not authorized in accordance with this Contract and Applicable Law, and shall implement and maintain safeguards to prevent unauthorized access.

e. **Access from Outside the US and it Territories** Contractor Access to the State network from outside the US and its territories is prohibited unless approved by the OHA Chief Information Risk Officer (CIRO). If approved, Contractor shall provide Administrative Notice to ISPO at DHSOHA.InfoEx@odhsoha.oregon.gov with the IP addresses, or IP address range, to be used to Access the network. Any changes to the provided IP addresses, or IP range, shall be immediately communicated to ISPO by Administrative Notice or Access could be affected.

f. **Authorized Access and Use Only.** No User may Access or use Data for any purpose other than those specifically authorized through this Contract.

(1) Users shall not use Access to obtain or attempt to obtain any Data or Information Assets not authorized or intentionally made available.

(2) The use and disclosure of any Information Asset is strictly limited to the minimum information necessary to the exchange of Data between the parties described in Form MSC 0785.

(3) Except as otherwise specified or approved by OHA, neither Contractor nor its Users may modify, alter, delete, or destroy any Information Asset.

g. **Revocation or Termination of Access.** Breach, or wrongful use or disclosure of Information Assets by Contractor or its Users, may cause the immediate revocation of the Access granted though this Ex. N, in the sole discretion of OHA, or OHA may specify a reasonable opportunity for Contractor to cure the unauthorized use or disclosure and end the violation, and terminate the Access if Contractor does not do so within the time specified by OHA. Legal actions also may be taken for violations of Applicable Laws.

h. **No Unauthorized Distribution.** Contractor shall not sell, make available, or provide Information Assets in any form to any other persons or organizations, and shall not use the Information Assets for any purposes other than as allowed under this Contract and Applicable Law.

i. **No Impairment.** Contractor shall not use this Access in any manner which could damage, disable, overburden, or impair Network and Information Systems or interfere with any other entity's use or benefit of Network and Information Systems.

j. **Prohibition on Data Mining**. Contractor shall not capture, maintain, scan, index, share or use Data stored or transmitted by virtue of this interconnection, or otherwise use any data-mining technology, for any non-authorized activity. For purposes of this requirement, "non-authorized activity" means the data mining or processing of data, stored, or transmitted through the Network and Information Systems, for unrelated commercial purposes, advertising, or advertising-related purposes, or for any other purpose other than security analysis that is not explicitly authorized in this Contract.

k. **Incidents and Breaches.** Contractor shall comply, and shall cause its Subcontractors to comply, with any requirements for identifying and addressing an Incident or Breach. This requirement applies regardless of whether the Incident or Breach was accidental or otherwise.

9. Sanctions for Breach

a. Contractor's breach of this Ex. N may result in one or more Sanctions identified in OAR 410-141-3530 and 410-141-3531. Sanctions may include, without limitation, (i) immediate revocation or modification of the Access granted Contractor or (ii) termination of the Contract. In the event Access is immediately revoked or modified, OHA will provide subsequent written notice to Contractor's point of contact. However, OHA may, in its reasonable discretion, provide advance written notice of OHA's intent to revoke or modify Contractor's Access and give Contractor an opportunity to cure its breach prior to such revocation or modification. Without limiting the foregoing, any Sanction that may be imposed under this Sec. 9 will comply with Secs. 8 and 9 of Ex. B, Pt. 9 of the Contract.

b. OHA may modify Access, upon written notice if there are changes to or revised interpretations of federal or state laws, rules, or regulations, or if either party has changes in policies that require such action.

c. Any revocation or modification by OHA of Access granted Contractor does not alter Contractor's obligations to comply with the remaining provisions of this Contract.

10. Survival

This Ex. N shall survive termination of this Contract for so long as Contractor retains Access to OHA, State Data, Network and Information Systems, and Information Assets. Moreover, Contractor shall maintain protections required by law or the Contract for any retained Member medical records or State of Oregon Information Asset(s), or both, for so long as Contractor (including through any Subcontractor or Agent) retains it.

11. Costs

Each party will bear its own costs related to the acquisition of all equipment, software, data lines or connections necessary for Access, unless otherwise agreed to by written agreement between the parties. Each party is responsible for securing compatible hardware, equipment, and software, and network connections. Each party is responsible for complying with the licenses for third party products, including software and services that allow Access.

12. Interpretation

Any ambiguity in this Ex. N will be resolved to permit OHA to comply with Applicable Laws pertaining to privacy and security and State of Oregon and OHA policies interpreting those laws.

13. Subcontractors

Contractor shall ensure all Subcontractors and Agents with Access as defined in this Ex. N are held to the same requirements as Contractor.

[Remainder of page intentionally left blank]

General Provisions – Attachment 1

Permanent URLs for OARs

General Provisions		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3501	Administration of Oregon Integrated and Coordinated Health Care Delivery System Regulation; Rule Precedence	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3501
410-141-3700[58]	CCO Application and Contracting Procedures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3700
410-141-3725	CCO Contract Renewal Notification	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3725

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
137-004-0080	Reconsideration — Orders in Other than Contested Case	https://secure.sos.state.or.us/oard/view.action?ruleNumber=137-004-0080
137-004-0092	Stay Proceeding and Order — Orders in Other than Contested Case	https://secure.sos.state.or.us/oard/view.action?ruleNumber=137-004-0092
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0167	Intensive In-Home Behavioral Health Treatment (IIBHT) for Children	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0167
309-019-0225	Assertive Community Treatment (ACT) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0225
309-022-0105	Definitions (Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-022-0105
309-032-0860	Definitions (Community Treatment and Support Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0860
309-036-0105	Definitions (Community Mental Health Housing Fund)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-036-0105
409-055-0040	Recognition Criteria	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0040
410-120-0000	Acronyms and Definitions (Medical Assistance Programs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-0000
410-120-1210[59]	Medical Assistance Benefit Packages and Delivery System	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1210
410-120-1990	Telehealth	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1990

[58] This existing OAR will be updated effective 1/1/2026.
[59] This existing OAR will be updated effective 1/1/2026.

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3500	Definitions (Oregon Health Plan)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3500
410-141-3525	Outcome and Quality Measures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3525
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3575[60]	MCE Member Relations: Marketing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3575
410-141-3700	CCO Application and Contracting Procedures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3700
410-141-3710	Contract Termination and Close-Out Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3710
410-141-3725	CCO Contract Renewal Notification	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3725
410-141-3730	Community Health Assessment and Community Health Improvement Plans	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3730
410-141-3735	Social Determinants of Health and Equity; Health Equity	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3735
410-141-3810	Disenrollment from MCEs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3820	Covered Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3820
410-141-3845	Flexible Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3845
410-141-3855	Pharmaceutical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3855
410-141-3865	Care Coordination: Identification of Member Needs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3865
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-141-3875	MCE Grievances & Appeals: Definitions and General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3875
410-141-3890	Grievances & Appeals: Appeal Process	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3890
410-141-5285[61]	CCO Holding Company Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5285
410-170-0020	Definitions (Behavior Rehabilitation Services Program General Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-170-0020

[60] This existing OAR will be updated effective 1/1/2026.
[61] This existing OAR will be updated effective 1/1/2026 for Enrolled Oregon Senate Bill 831 (2025).

Definitions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 410, Division 172	Medicaid Payment for Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1740
950-060-0010	Definitions (Traditional Health Workers)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=950-060-0010
410-200-0400	Specific Requirements; Breast and Cervical Cancer Treatment Program (BCCTP)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-200-0400
Chapter 411, Division 4	Home and Community-Based Services and Settings and Person-Centered Service Planning	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1746
461-195-0301	Definitions (Liens, Overpayments and IPVs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0301
461-195-0303	Personal Injury Claim	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0303
943-090-0010	Definitions (Cultural Competency Continuing Education for Health Care Professionals)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-090-0010
943-120-0100	Definitions (Provider Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0100
943-120-0200	Authority System Administration	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0200

Exhibit B – Statement of Work – Part 1 – Governance and Organizational Relationships		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3715[62]	CCO Governance; Public Meetings and Transparency	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3715

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
309-019-0155	Enhanced Care Services (ECS) and Enhanced Care Outreach Services (ECOS)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0155
333-006-0160	Health Benefit Plans Reporting Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=333-006-0160
410-120-0000[63]	Acronyms and Definitions (Medical Assistance Programs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-0000
410-120-1210	Medical Assistance Benefit Packages and Delivery System	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1210
410-120-1990	Telehealth	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1990
410-120-2000[64]	HRSN Services Delivery	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324055

[62] This existing OAR will be updated effective 1/1/2026.
[63] This existing OAR will be updated effective 1/1/2026.
[64] This existing OAR will be updated effective 1/1/2026.

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-2005[65]	HRSN Service Eligibility; Identifying HRSN Eligible Members, HRSN Outreach and Engagement Services	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324058
410-120-2010[66]	HRSN Service Requests	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324059
410-120-2015[67]	HRSN Eligibility Screening	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324060
410-120-2020[68]	Authorization of HRSN Services; Referral to HRSN Service Provider	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324061
410-120-2025	HRSN Person-Centered Service Plan (PCSP)	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324062
410-120-2030[69]	HRSN Service Provider Qualifications	https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=324063
410-123-1220	Coverage According to the Prioritized List of Health Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1220
410-123-1260	OHP Dental Benefits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1260
Chapter 410, Division 124	Transplant Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1712
410-130-0190	Tobacco Cessation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0190
410-130-0230	Administrative Medical Examinations and Reports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0230
410-130-0240	Medical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0240
410-130-0580	Hysterectomies and Sterilization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0580
410-130-0585	Family Planning Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0585
410-136-3020	General Requirements for NEMT	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-136-3020
Chapter 410, Division 141	Oregon Health Plan	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728
410-141-3510[70]	Provider Contracting and Credentialing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3510

[65] This existing OAR will be updated effective 1/1/2026.
[66] This existing OAR will be updated effective 1/1/2026.
[67] This existing OAR will be updated effective 1/1/2026.
[68] This existing OAR will be updated effective 1/1/2026.
[69] This existing OAR will be updated effective 1/1/2026.
[70] This existing OAR will be updated effective 1/1/2026.

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3585	MCE Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3820[71]	Covered Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3820
410-141-3825	Excluded Services and Limitations	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3825
410-141-3830	Prioritized List of Health Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3830
410-141-3835[72]	MCE Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-3855[73]	Pharmaceutical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3855
410-141-3870[74]	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-141-3915	Grievances & Appeals: System Recordkeeping	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3915
410-141-3920	Transportation: NEMT General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3920
410-141-3925	Transportation: Vehicle Equipment and Driver Standards	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3925
410-141-3935	Transportation: Attendants for Child and Special Needs Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3935
410-141-3940	Transportation: Secured Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3940
410-141-3945	Transportation: Ground and Air Ambulance Transports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3945
410-141-3955[75]	Transportation: Member Service Modifications and Rights	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3955
410-141-3965	Reports and Documentation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3965

[71] This existing OAR will be updated effective 1/1/2026.
[72] This existing OAR will be updated effective 1/1/2026.
[73] This existing OAR will be updated effective 1/1/2026.
[74] This existing OAR will be updated effective 1/1/2026.
[75] This existing OAR will be updated effective 1/1/2026 to define "chronic lateness" and add it as a service modification.

Exhibit B – Statement of Work – Part 2 – Covered and Non-Covered Services		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 410, Division 151[76]	Early and Periodic Screening, Diagnostic and Treatment	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=8155
Chapter 410, Division 172	Medicaid Payment for Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1740
Chapter 410, Division 173	1915(i) Home and Community Based Services State Plan Option	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5379
Chapter 411, Division 34	State Plan Personal Care Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1764
Chapter 943, Division 45	Office of Training, Investigations and Safety – Adult Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4204

Exhibit B – Statement of Work – Part 3 – Patient Rights and Responsibilities, Engagement and Choice		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3575	MCE Member Relations: Marketing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3575
410-141-3580	MCE Member Relations: Potential Member Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3580
410-141-3585	MCE Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585
410-141-3590	MCE Member Relations: Member Rights and Responsibilities	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3590
410-141-3805	Mandatory MCE Enrollment Exceptions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3805
410-141-3810[77]	Disenrollment from MCEs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
Chapter 950, Division 50[78]	Standards for Health Care Interpreter Registry Enrollment and Requirements to Work with Qualified or Certified Health Care Interpreters	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7797

Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems		
OAR	**Rule Title**	**Permanent Link to OAR**
409-055-0000	Purpose and Scope (Patient-Centered Primary Care Homes)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0000
409-055-0090	Reimbursement Objectives	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-055-0090

[76] OHA expects to renumber the EPSDT rules in OAR Chapter 410, Division 151 during 2026.
[77] This existing OAR will be updated effective 1/1/2026.
[78] This existing OAR will be updated effective 11/1/2025.

Exhibit B – Statement of Work – Part 4 – Providers and Delivery Systems		
OAR	**Rule Title**	**Permanent Link to OAR**
410-123-1510	Additional Dental Care Benefits for Pregnant Individuals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1510
410-141-3510	Provider Contracting and Credentialing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3510
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3560	Resolving Contract Disputes Between Health Care Entities and CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3560
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3805	Mandatory MCE Enrollment Exceptions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3805
410-141-3810	Disenrollment from MCEs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3850	Transition of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3850
410-141-3860	Care Coordination: Administration, Systems and Infrastructure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3860
410-141-3865	Care Coordination: Identification of Member Needs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3865
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-170-0090	BRS Types of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-170-0090
Chapter 950, Division 50[79]	Standards for Health Care Interpreter Registry Enrollment and Requirements to Work with Qualified or Certified Health Care Interpreters	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7797
950-060-0070	Background Check Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=950-060-0070

Exhibit B, Parts 5 through 7 are reserved.

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
409-025-0100	Definitions (All Claims All Payer Data Reporting Program)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0100
409-025-0160	Data Access and Release	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0160
409-025-0170	Public Disclosure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0170
409-025-0190	Data Review Committee	https://secure.sos.state.or.us/oard/view.action?ruleNumber=409-025-0190

[79] This existing OAR will be updated effective 11/1/2025.

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 409, Division 65	Sustainable Health Care Cost Growth Target Program	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882
Chapter 409, Division 70	Health Care Market Oversight Program	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6980
Chapter 410, Division 120	Medical Assistance Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1708
410-120-1260	Provider Enrollment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1260
410-120-1280	Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1280
410-120-1295	Non-Participating Provider	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1295
410-120-1300	Timely Submission of Claims	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1300
410-120-1340	Payment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1340
410-120-1560	Provider Appeals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1560
Chapter 410, Division 121	Pharmaceutical Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1709
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3570[80]	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3810	Disenrollment from MCEs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3810
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-5320	CCO Holding Company Regulation: Transactions Within Holding Company	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5320
410-141-5325	CCO Holding Company Regulation: Director and Officer Liability; Effect of Control of CCO Subject to Registration; Board of Directors	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5325
410-141-5310	CCO Holding Company Regulation: Presumption of Control; Rebuttal	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5310

[80] This existing OAR will be updated effective 1/1/2026.

Exhibit B – Statement of Work – Part 8 – Accountability and Transparency of Operations		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-5315	CCO Holding Company Regulation: Disclaimer of Affiliation	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5315
461-195-0301	Definitions (Liens, Overpayments and IPVs)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0301
461-195-0303	Personal Injury Claim	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0303
461-195-0325	Release or Compromise of Lien	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0325
461-195-0350	Procedure Where Injured Recipient is a Minor	https://secure.sos.state.or.us/oard/view.action?ruleNumber=461-195-0350
943-014-0010	Purpose (Privacy and Confidentiality)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0010
943-014-0300	Scope (Privacy and Confidentiality)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0300
943-014-0320	User Responsibility	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-014-0320
943-120-0100	Definitions (Provider Rules)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0100
943-120-0200	Authority System Administration	https://secure.sos.state.or.us/oard/view.action?ruleNumber=943-120-0200

Exhibit B – Statement of Work – Part 9 – Program Integrity		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-1396	Provider and Contractor Audits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1396
410-120-1510	Fraud and Abuse	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1510
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1580
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3530	Sanctions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3530
410-141-3531	Sanctions for Failure to Comply with State or Federal Information Security or Privacy Laws	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3531
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3625	MCE Assessment: Authority to Audit Records	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3625
410-141-3835	MCE Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835

Exhibit B – Statement of Work – Part 10 – Transformation Reporting, Performance Measures and External Quality Review		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3525[81]	Outcome and Quality Measures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3525

Exhibit C – Consideration		
OAR	**Rule Title**	**Permanent Link to OAR**
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0145	Co-Occurring Mental Health and Substance Use Disorders (COD)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0145
Chapter 309, Division 65	Culturally and Linguistically Specific Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7587
Chapter 410, Division 120	Medical Assistance Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1708
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1580
410-123-1260	OHP Dental Benefits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-123-1260
410-125-0230	Qualified Directed Payments	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-125-0230
410-130-0580	Hysterectomies and Sterilization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-130-0580
410-136-3371	Provider Requirements and Payment Processing for the CCO GEMT Supplemental Payments	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-136-3371
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3855	Pharmaceutical Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3855

Exhibit D – Standard Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 12	Administrative Practice and Procedure	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1009
Chapter 309, Division 14	Community Mental Health Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1011

[81] This existing OAR will be updated effective 1/1/2026.

Exhibit D – Standard Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 15	Medicaid Payment for Inpatient Psychiatric Hospital Inpatient Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1012
Chapter 309, Division 18	Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015
Chapter 309, Division 19	Outpatient Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1016
Chapter 309, Division 22	Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1019
Chapter 309, Division 32	Community Treatment and Support Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1026
Chapter 309, Division 40	Adult Foster Homes	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1034
410-120-1560	Provider Appeals	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1560
410-120-1580	Provider Appeals — Administrative Review	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1580
Chapter 410, Division 141	Oregon Health Plan	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1728
410-141-3710	Contract Termination and Close-Out Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3710
410-141-5080	Financial Solvency Regulation: Transparency	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5080
Chapter 419, Division 210	Office of Training, Investigations and Safety – Child-In-Care Abuse Investigations	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=8763
Chapter 419, Division 240	Office of Training, Investigations and Safety – Child Abuse Investigations by Third Party	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=8766
Chapter 943, Division 45	Office of Training, Investigations and Safety – Adult Abuse	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4204

Exhibit E – Required Federal Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
199-005-0001	Definitions (Gifts)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=199-005-0001
199-005-0030	Determining the Source of Gifts	https://secure.sos.state.or.us/oard/view.action?ruleNumber=199-005-0030

Exhibit E – Required Federal Terms and Conditions		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 407, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1629
410-120-1380	Compliance with Federal and State Statutes	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1380
Chapter 943, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4203

Exhibit F – Insurance Requirements		
OAR	**Rule Title**	**Permanent Link to OAR**
None		

Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515

Exhibit H – Value Based Payment		
OAR	**Rule Title**	**Permanent Link to OAR**
None		

Exhibit I – Grievance and Appeal System		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-1860	Contested Case Hearing Procedures	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1860
410-141-3585	MCE Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3835	MCE Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3850	Transition of Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3850
410-141-3875	MCE Grievances & Appeals: Definitions and General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3875
410-141-3880	Grievances & Appeals: Grievance Process Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3880
410-141-3885[82]	Grievances & Appeals: Notice of Action/Adverse Benefit Determination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3885
410-141-3890[83]	Grievances & Appeals: Appeal Process	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3890

[82] This existing OAR will be updated effective 1/1/2026.
[83] This existing OAR will be updated effective 1/1/2026.

Exhibit I – Grievance and Appeal System		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3895	Grievances & Appeals: Expedited Appeal	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3895
410-141-3900[84]	Grievances & Appeals: Contested Case Hearings	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3900
410-141-3905	Grievances & Appeals: Expedited Contested Case Hearings	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3905
410-141-3910	Grievances & Appeals: Continuation of Benefits	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3910
410-141-3915	Grievances & Appeals: System Recordkeeping	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3915
410-141-3920	Transportation: NEMT General Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3920

Exhibit J – Health Information Technology		
OAR	**Rule Title**	**Permanent Link to OAR**
410-120-1280	Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-120-1280
410-141-3520	Record Keeping and Use of Health Information Technology	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3520
410-141-3565	Managed Care Entity Billing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3565
410-141-3570	Managed Care Entity Encounter Claims Data Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3570
410-141-3591[85]	MCE Interoperability Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3591
Chapter 943, Division 120	Provider Rules	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4208

Exhibit K – Social Determinants of Health and Equity		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-3500	Definitions (Oregon Health Plan)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3500
410-141-3730[86]	Community Health Assessment and Community Health Improvement Plans	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3730
410-141-3735	Social Determinants of Health and Equity; Health Equity	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3735
410-141-3845	Flexible Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3845

[84] This existing OAR will be updated effective 1/1/2026.
[85] This existing OAR will be updated effective 1/1/2026.
[86] This existing OAR will be updated effective 1/1/2026.

410-141-5000	Financial Solvency Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5000

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-5000	Financial Solvency Regulation: Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5000
410-141-5005	Financial Solvency Regulation: CCO Financial Solvency Requirement	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5005
410-141-5010	Financial Solvency Regulation: Procedure for General Financial Reporting and for Determining Financial Solvency Matters	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5010
410-141-5015[87]	Financial Solvency Regulation: Financial Statement Reporting	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5015
410-141-5020	Financial Solvency Regulation: Annual Audited Financial Statements and Auditor's Report	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5020
410-141-5045	Financial Solvency Regulation: Corporate Governance Annual Disclosure Filing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5045
410-141-5050	Financial Solvency Regulation: Requirements for Reinsurance	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5050
410-141-5055	Financial Solvency Regulation: Requirements for Obtaining Credit for Reinsurance	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5055
410-141-5075	Financial Solvency Regulation: Disallowance of Certain Reinsurance Transactions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5075
410-141-5170	Capitalization: Capital and Surplus	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5170
410-141-5180	Capitalization: Dividend and Distribution Restrictions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5180
410-141-5185	Capitalization: Restricted Reserve Account	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5185
410-141-5195	Capitalization: Risk-based Capital (RBC) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5195
410-141-5200	Capitalization: RBC Reports	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5200
410-141-5205	Capitalization: Company Action Level Event	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5205
410-141-5220	Capitalization: Mandatory Control Level Event	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5220
410-141-5225	Reporting and Approval of Certain Transactions: Extraordinary Dividends and Other Distributions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5225
410-141-5240	Reporting and Approval of Certain Transactions: Materiality and Reporting Standards for Changes in Ceded Reinsurance Agreements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5240

[87] This existing OAR will be updated effective 1/1/2026.

Exhibit L – Solvency Plan, Financial Reporting, and Sustainable Rate of Growth		
OAR	**Rule Title**	**Permanent Link to OAR**
410-141-5245	Examinations: CCO Production of Books and Records	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5245
410-141-5250	Examinations: Authority Examinations of CCOs	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5250
410-141-5300	CCO Holding Company Regulation: Registration Statement Filing	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5300
410-141-5320	CCO Holding Company Regulation: Transactions Within Holding Company	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5320
410-141-5330	CCO Holding Company Regulation: Annual Enterprise Risk Report	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5330
410-141-5380	Civil Penalties	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-5380

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 309, Division 18	Residential Substance Use Disorders and Problem Gambling Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015
Chapter 309, Division 19	Outpatient Behavioral Health Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1016
309-019-0105	Definitions (Outpatient Behavioral Health Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0105
309-019-0135	Entry and Assessment	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0135
309-019-0162	Youth Wraparound Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0162
309-019-0163	Youth Wraparound Program Rules	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0163
309-019-0225	Assertive Community Treatment (ACT) Definitions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0225
309-019-0275	Individual Placement and Support (IPS) Supported Employment Overview	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0275
309-019-0295	Reporting Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0295
309-019-0300	Service Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0300
309-019-0320	Documentation Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-019-0320
Chapter 309, Division 22	Children & Adolescents: Intensive Treatment Services; Integrated Licenses; Children's Emergency Safety Intervention Specialists	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1019
309-022-0155	General Staffing Requirements	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-022-0155

Exhibit M – Behavioral Health		
OAR	**Rule Title**	**Permanent Link to OAR**
309-032-0850	Purpose (Community Treatment and Support Services)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0850
309-032-0870	Standards for Approval of Regional Acute Care Psychiatric Service	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-032-0870
309-033-0200	Statement of Purpose and Statutory Authority (Involuntary Commitment Proceedings)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0200
309-033-0640	Involuntary Administration of Significant Procedures to a Committed Person With Good Cause	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0640
309-033-0740	Variances	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-033-0740
309-091-0000	Purpose and Scope (State Hospital Admissions and Discharges)	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0000
309-091-0015	Determining Need for State Hospital Care	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0015
309-091-0050	Other Forensic Discharges	https://secure.sos.state.or.us/oard/view.action?ruleNumber=309-091-0050
410-141-3515	Network Adequacy	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3515
410-141-3585	MCE Member Relations: Education and Information	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3585 d
410-141-3835	MCE Service Authorization	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3835
410-141-3840	Emergency and Urgent Care Services	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3840
410-141-3860	Care Coordination: Administration, Systems and Infrastructure	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3860
410-141-3870	Care Coordination: Service Coordination	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3870
410-172-0690	Admission Procedure for Psychiatric Residential Treatment Services for Children	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-172-0690
Chapter 415, Division 12	Licensure of Substance Use Disorders and Problem Gambling Residential Treatment and Recovery Services	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1922
Chapter 415, Division 20	Standards for Outpatient Opioid Treatment Programs	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1923
Chapter 415, Division 50	Standards for Alcohol Detoxification Centers	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1924

Exhibit N – Privacy and Security		
OAR	**Rule Title**	**Permanent Link to OAR**
Chapter 407, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1629
410-141-3530	Sanctions	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3530
410-141-3531	Sanctions for Failure to Comply with State or Federal Information Security or Privacy Laws	https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-141-3531
Chapter 943, Division 14	Privacy and Confidentiality	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=4203

[Remainder of page intentionally left blank]

Exhibit C – Attachment 1

CCO Payment Rates

Exhibit D – Attachment 1

Deliverables and Required Notices