**OREGON HEALTH PLAN**

**Amended and Restated**

**HEALTH PLAN SERVICES CONTRACT**

**Dental Care Organization**

**Contract # «Contract_»-«Next_amend_»**

**with**

***«Registered_Name» «Registered_ABN»***

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# OREGON HEALTH PLAN
# HEALTH PLAN SERVICES CONTRACT
# DENTAL CARE ORGANIZATION
# GENERAL PROVISIONS

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

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

**«Physical_AddressStreet»**
**«Physical_AddressCityStateZip»**

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

The Contract, as amended and restated in its entirely effective January 1, 2021, is hereby further amended and restated in its entirety effective as of January 1, 2022 ("**2022 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 2022 A&R Effective Date.

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

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

## 1. Effective Date and Annual Approval; Duration of Contract

This Contract, including the DCO 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 2022 DCO Payment Rates prior to the 2022 A&R Effective Date, OHA will pay Contractor at the proposed DCO Payment Rates and Contractor shall accept payment at the proposed DCO Payment Rates, subject to adjustment upon CMS approval or OHA modification of the DCO Payment Rates.

**1.1.** The term of this Contract is one (1) year from its effective date of January 1, 2022, unless terminated earlier as provided for in the Contract. OHA may offer to Renew the Contract for an additional one (1) year term. OHA will provide such proposed amendments not less than one hundred four (104) days prior to the effective date of the succeeding Contract Year. 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 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_Contract_admin_per_Section»
«Registered_Name» «Registered_ABN»
«Mailing_AddressStreetPOB»
«Mailing_AddressCityStateZip»
Phone: «PhonePrimary»
Fax: «FaxPrimary»
Email: «EmailPrimary»

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

**2.2.** OHA designates:

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

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

## 3. Enrollment Limits and Service Area

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

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

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

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

**3.2.** Contractor's maximum Enrollment limit is: ***(Specific Plan Enrollment Limits)***. The maximum Enrollment limit established in this section is expressly subject to such additional Enrollment as may be assigned to Contractor by OHA in Ex. B, Part 3 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 and Cooperative Agreements |
| **Exhibit H:** | RESERVED |
| **Exhibit I:** | Grievance and Appeal System |
| **Exhibit J:** | Health Information Technology |
| **Exhibit K:** | Health Equity |
| **Exhibit L:** | Solvency Plan and Financial Reporting |
| **Exhibit M:** | RESERVED |
| **Exhibit N:** | Privacy and Security |

*Exhibit C-Attachment 1 (DCO 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 DCO Contract Forms Website located at: https://www.oregon.gov/OHA/HSD/OHP/Pages/DCO-Contract-Forms.aspx and other webpages expressly referenced in this Contract and are by this reference incorporated into the Contract. OHA may change the DCO Contract Forms Website URL after providing Administrative Notice of such change, with such change to be effective as of the date identified in such Administrative Notice.

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

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

### 4.3. Interpretation of Contract

In the provision of services required to be performed under this Contract, the Parties shall comply with: (a) all Applicable Laws and regulations and (b) the terms and conditions of this Contract and all amendments thereto that are in effect on the Contract Effective Date or come into effect during the Term of this Contract. In the event Contractor Subcontracts any of its obligations under this Contract, Contractor shall only do so in accordance with the terms and conditions set forth in Ex. B, Part 4 of this Contract and any other applicable provisions of this Contract.

**4.3.1.** To the extent provisions contained in more than one of the documents listed in 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 following order of precedence only in the event of an irreconcilable conflict:

**4.3.1.1.** These General Provisions of the Contract (without Exhibits, Exhibit attachments, or Reference Documents) over any Exhibits, Exhibit attachments, or Reference Documents.

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

**i.** Exhibit E: Required Federal Terms and Conditions

**ii.** Exhibit 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 and Financial Reporting

**viii.** Exhibit I: Grievance and Appeal System

**ix.** Exhibit G: Reporting of Delivery System Network Providers and Cooperative Agreements

**x.** Exhibit K: Health Equity

**xi.** Exhibit J: Health Information Technology

**xii.** Exhibit F: Insurance Requirements

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

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

## 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. 10.

***Please print or type the following information:***

Name (exactly as filed with the IRS)

_____

Street Address _____

City, State, Zip Code _____

Telephone _____ Facsimile Number _____

E-mail address: _____

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 Company _____

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.** The Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) Contractor and that pertains to this Contract.

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

**5.1.1.2.** In addition to the remedies under this Contract, if Contractor makes (or causes to be made) a False Claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against Contractor.

**5.1.2.** Contractor has a written policy and practice that meets the requirements, described in ORS 279A.112, of preventing sexual harassment, sexual assault, and discrimination against employees who are members of a protected class.

**5.1.2.1.** Contractor agrees, as a material term of the Contract, to maintain such a policy and practice in force during the entire Contract Term.

**5.1.3.** Under penalty of perjury, the undersigned is authorized to act on behalf of Contractor and that Contractor is, to the best of the undersigned's knowledge after due inquiry for a period of no fewer than six (6) calendar years preceding the Contract Effective Date, has complied with all applicable Oregon Tax Laws. For purposes of this certification, "Oregon Tax Laws" means a State tax imposed by ORS 320.005 to 320.150 and 403.200 to 403.250 and ORS Chapters 118, 314, 316, 317, 318, 321 and 323; and local taxes administered by the Department of Revenue under ORS 305.620;

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

**5.1.5.** The information shown in 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:

**a.** Contractor is exempt from backup withholding;

**b.** Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of a failure to report all interest or dividends; or

**c.** The IRS has notified Contractor that Contractor is no longer subject to backup withholding.

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

**5.2.** By Contractor's signature on this Contract, Contractor hereby certifies that the FEIN provided in Sec. 5.1 above of these General Provisions is true and accurate. If this information changes, Contractor shall provide OHA with the new FEIN within ten (10) days of the date of change.

**5.3. Signatures**

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

**«Registered_Name» «Registered_ABN»**
**By:**

| | |
|---|---|
| Authorized Signature | Printed Name |
| Title | Date |

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

| | |
|---|---|
| David Inbody, CCO Operations Manager | Date |

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

| | |
|---|---|
| Dana Hittle, Interim Medicaid Director | Date |

**Approved as to Legal Sufficiency:**
**Electronic approval by Theodore C. Falk, Senior Assistant Attorney General, Health and Human Services Section, on September 16, 2021; email in Contract file.**

## Exhibit A – Definitions

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

1. Express definitions in Ex. A,
2. Express definitions elsewhere in this Contract,
3. Definitions in the OARs cited in Ex. A, and
4. 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.

**"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.

**"2022 A&R Effective Date"** means the date on which this Contract became effective, as amended and restated, which is January 1, 2022.

**"AP Standard"** means the standard for accurate and timely submission of all Valid Claims for a Subject Month within 45 days of the date of adjudication and the correction of Encounter Data requiring correction within 63 days of the date of notification, applying the standard in OAR 410-141-3570 in effect for the Subject Month.

**"AP Withhold"** and **"Administrative Performance Withhold"** and **"AP Withhold"** and **"APW"** each means the dollar amount equal to one percent (1%) of Contractor's adjusted Capitation Payment paid for the Subject

Month (including monthly and weekly payments combined for the Subject Month as described in Ex. C, Sec. 4) that will be withheld during the Withhold Month.

**"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. 6, Ex C. of this Contract.

**"Adjudication"** has the meaning provided in OAR 410-141-3500. For purposes of Encounter Data, "Adjudication" means the date on which Contractor has both (a) processed and (b) either paid or denied a Member's claim for services.

**"Administrative Notice"** (also "**Administrative Notification**") means a notice from Contractor to OHA, or from OHA to Contractor, which is for purposes of administering the Contract and which meets the requirements set forth in Sec. 24, 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.

**"Advance Directive"** means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated pursuant to 42 CFR 438.3(j); 42 CFR 422.128; and 42 CFR 489.100. A "health care instruction" means a document executed by a principal to indicate the principal's instructions regarding health care decisions. A "power of attorney for health care" means a power of attorney document that authorizes an attorney-in-fact to make health care decisions for the principal when the principal is incapable. "Incapable" means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal's attending Physician, a principal lacks the ability to make and communicate health care decisions to health care Providers, including communication through persons familiar with the principal's manner of communicating if those persons are available.

**"Adverse Benefit Determination"** has the meaning provided for in OAR 410-141-3875.

**"Affiliate"** means a Person that directly, or indirectly through one or more intermediaries, Controls, or is Controlled by, or is under common Control with, the Person specified.

**"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.

**"Agreed Upon Procedures"** means those procedures or audit standards agreed upon by OHA, Contractor, and an independent third-party auditor, and which are undertaken, at the request of Contractor, by the independent third-party auditor for the purpose of issuing a report of factual findings, exclusive of opinions, conclusions, or assurances, about the financial circumstances of Contractor's business. The acronym "AUP" has the same meaning.

**"All Plan System Technical Meeting(s)**" and **"APST Meeting(s)"** each means those teleconference meetings for all MCEs, 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. 8, Para. b.

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

**"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 410-120-0000. "**Indian**" has the same meaning.

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

**"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.

**"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.

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

**"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 DCO 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 DCO 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.

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

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

**"Business Day"** has the meaning provided for in OAR 410-141-3500.

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

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

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

**"Care Coordination"** means the organized coordination of a Member's health care services and support activities and resources. The coordination occurs between and among two or more participants deemed responsible for the Member's health outcomes and includes, at minimum, the Member (and their Family/caregiver as appropriate) and the Member's assigned Care Coordinator. Organizing and facilitating the appropriate delivery of health care services, supports, and resources involves a team-based approach focused on the needs and strengths of the individual Member. Successful Care Coordination requires the exchange of information among Care Coordinating participants, explicit assignments for the functions of specific Care Coordinating participants, and addresses the Member's interrelated and interdependent medical, social, cultural, developmental, behavioral, educational, spiritual, and financial needs in order to achieve optimal health and wellness outcomes. Successful Care Coordination is achieved when a Member's health care team, including the Member and Family/caregiver, supported by the integration of all necessary information and resources, chooses and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for the Member. Care Coordination contributes to a patient-centered, high-value, high-quality care system.

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

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

**"Centers for Medicare and Medicaid Services"** and **"CMS"** each means the federal agency within the Department of Health and Human Services that administers Medicare and works in partnership with all fifty states to administer Medicaid.

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

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

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

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

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

**"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 410-120-0000.

**"Clinical Record"** 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 can be found at the following URL: https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

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

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

**"Community Health Worker"** has the meaning provided for in OAR 410-120-0000.

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

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

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

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

**"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 Amended and Restated Contract becomes effective as identified in Sec. 1 of the General Provisions of this Contract.

**"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 the party that entered into this Contract with OHA.

**"Control"** including its use in the terms "Controlling," "Controlled," "Controlled by" and "under common Control with," means possessing the direct or indirect power to manage a Person or set the Person's policies, whether by owning voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position or corporate office the Person holds. OHA shall presume that a Person controls another Person if the Person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of the other Person.

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

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

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

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

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

**"Covered Services"** has the meaning provided for in OAR 410-141-3820.

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

**"COVID-19 Emergency"** means the period:

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

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

**"Culturally and Linguistically Appropriate 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 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.

"**DCO Contract Forms Website**" means the OHA website located at: https://www.oregon.gov/OHA/HSD/OHP/Pages/DCO-Contract-Forms.aspx.

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

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

**"Dental"** means having to do with the teeth.

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

**"Dental Case Management Services"** means a comprehensive, ongoing assessment of dental and medical needs related to dental health plus the development and implementation of a plan to obtain needed Dental Services that are Capitated Services or non-Capitated Services, and follow up, as appropriate to assess the impact of care.

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

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

**"Dental Hygienist with an Expanded Practice Permit"** has the meaning as provided in OAR 410-120-0000.

**"Dental Post-Stabilization Services"** means Covered Services related to an Emergency Dental 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, the Contractor cannot be contacted, or the Contractor's representative and the treating dentist cannot reach an agreement concerning the Member's care and a Contractor Dentist is not available for consultation. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the DCO is responsible, the rules under 42 CFR § 438.114 apply.

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

**"Dental Urgent Care"**[1] has the meaning provided for in OAR 410-123-1060.

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

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

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

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

**"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.

**"Dual Special Needs Plan**" and **"DSNP"** means a specific type of Medicare Advantage Plan for those individuals who have special needs as defined in 42 CFR § 422.2 and meet the eligibility requirements set forth in 42 CFR § 422.52.

**"Durable Medical Equipment"** means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose.

**"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 DCOs, 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 Dental Condition"**[2] means a condition based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Emergency Dental Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth.

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

[1] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency
[2] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

"**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"**[3] means certain information required to be submitted to OHA under OAR 410-141-3570 and related to services that were provided to Members regardless of whether the services provided: (i) were Covered Services, non-covered services, or other Health-Related services; (ii) were not paid for; (iii) paid for on a Fee-For-Service or capitated basis; (iii) were performed by a Participating Provider, Non-Participating Provider, Subcontractor, or Contractor; and (iv) were performed pursuant to Subcontractor agreement, special arrangement with a facility or program, or other arrangement.

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

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

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

**"Expiration Date"** means the date the Term of this Contract expires, which is December 31, 2022, 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.

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

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

**"Fee-for-Service Provider"** and **"FFS Provider"** each has the meaning provided for in OAR 410-120-0000.

**"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.

[3] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency

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

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

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

**"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 DCO Contract Forms Website

**"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 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 DCOs under their contracts with OHA and which:

- **(i)** enables care coordination among Providers,
- **(ii)** contains costs through the sharing of dental information useful in diagnosis and treatment decision making,
- **(iii)** facilitates patient registries,
- **(iv)** enables unified quality reporting, and
- **(v)** empowers Members to participate in their overall wellness and health.

**"Health Insurance"** has the meaning provided in ORS 731.162.

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

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

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

**"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/

**"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).

**"Indian"** has the same meaning as **"American Indian/Alaska Native"** provided for in OAR 410-120-0000.

**"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.

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

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

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

**"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. 24, Para. a. of this Contract.

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

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

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

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

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

**"Material Change"**[4] means, in the context of Ex. G – Reporting of Delivery System Network Providers and Cooperative Agreements:

**(i)** Any change to Contractor's Delivery System Network (DSN) that may result in more than five (5) percent of its Members in a given county or Service Area changing the physical location(s) of where services are received; or

[4] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**(ii)** Any change to Contractor's DSN that would likely affect less than five (5) percent of its Members but involves a Provider or Provider group that is the sole provider specialty type in a given county, Service Area, or area with limited choice to accessible services; or

**(iii)** Any change in Contractor's overall operations that affects its ability to meet a required DSN standard including, but not limited to termination or loss of a Provider or Provider group, or any change likely to affect more than five (5) percent of Contractor's total Members or Provider Network or both; or

**(iv)** Any combination of the above changes.

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

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

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

**"Medical Loss Ratio"** and **"MLR"** each means the proportion of revenues spent on clinical services, and quality health improvements compared to the proportion of revenue spent on overhead expenses such as marketing, salaries, administrative costs and the like.

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

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

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

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

**"Medicare Advantage"** 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.

**"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"** means a person who can make OHP related decisions for a Member who lacks the ability to make and communicate health care decisions to health care Providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A Member Representative may be, in the following order of priority:

**(i)** a person who is designated as the Member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian),

**(ii)** a spouse, or other Family member as designated by the Member, the Individual Service Plan Team (for Members with developmental disabilities),

**(iii)** a parent or legal guardian of a minor below the age of consent,

**(iv)** a DHS or OHA case manager or other DHS or OHA designee. For Members in the care or custody of DHS Children, Adults, and Families (CAF) or OYA, the Member Representative is DHS or OYA.

For Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the Member Representative is their parent or legal guardian.

**"Monitor"** means:

**(i)** to observe and check the progress or quality of something,
**(ii)** to undertake some acts over a period of time,
**(iii)** to otherwise engage in activities, or
**(iv)** any combination, or all, of the foregoing, which enables the party or persons undertaking such observations, acts, or activities to determine the quality, progress, or compliance (or any and all combination thereof) of the activities that are subject to observation, acts, or activities.

**"MWESB"** means Minority-owned, Women-owned, and Emerging Small Businesses as such terms are used in Oregon Executive Order 12-03.

**"National Practitioner Data Bank"** means the web-based repository of reports containing information on medical malpractice payment and certain adverse actions related to health care practitioners, Providers, and suppliers which was established by Congress in 1986.

**"National Provider Identifiers"** and "**NPIs**" each means the unique 10-digit identification number issued to health care Providers in the United States by the CMS.

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

**"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. 16 of Ex. B, Part 8 of this Contract.

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

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

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

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

**"Notice of Encounter Data Delay"** means the notice Contractor is required to provide to its designated Encounter Data Liaison as set forth in Ex. B, Part 8, Sec. 9.

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

**"OHPB"** means the Oregon Health Policy Board.

**"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.

**"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 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. 12 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.

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

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

**"Participating Provider"**[5] has the meaning provided for in OAR 410-141-3500.

**"Patient Protection and Affordable Care Act"** and **"PPACA"** and **"ACA"** each means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as modified by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

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

**"Performance Improvement Projects"** means those activities required, pursuant to 42 CFR § 438.330, to be undertaken by Contractor that must be designed to achieve significant improvement, sustained over time, in health outcomes and Member satisfaction and meet the elements set forth in 42 CFR § 438.330(d) and as set forth in further detail in Ex. B, Part 10 of the Contract.

**"Performance Issues"** means those issues or deficiencies identified by OHA indicating that:

- **(i)** quality or access to services are not being provided as required under the Contract,
- **(ii)** cost containment goals are being compromised,
- **(iii)** circumstances exist that affect Member rights or health, or
- **(iv)** any combination of or all of the forgoing issues. One or more Performance Issue(s) constitutes a breach of this Contract.

[5] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**"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 Injury Lien"** and **"PIL"** each means a lien for Personal Injuries (as such term is defined under OAR 461-195-0301) that is subject to administration by OHA and DHS under OAR 461-195-0303.

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

**"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. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the DCO is responsible, the rules under 42 CFR § 438.114 apply.

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

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

**"Predecessor DCO 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 that expired on December 31, 2021.

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

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

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

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

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

**"Primary Care Dentist"** and **"PCD"** each has the meaning provided for in OAR 410-120-0000.

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

**"Primary Prevention"** means preventing the onset of a disease or other medical condition by intervening, prior to the onset of any ill effects, with the goal of reducing risks or threats to health utilizing measures such as vaccinations, exercise, and altering or otherwise ceasing to engage in, unhealthy or unsafe behaviors (e.g., poor diet, tobacco use).

**"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.

**"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. 11 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:

- **(i)** Personal health information as defined and protected under 42 USC §§ 1320d to 1320d-9, 45 CFR parts 160 to 164, ORS 192.553 to 192.581, and ORS 179.505 to ORS 179.507;
- **(ii)** Drug and alcohol records as defined and protected under 42 USC § 290dd-2, 42 CFR part 2, and ORS 430.399(6);
- **(iii)** Genetic information as defined and protected under ORS 192.531 to 192.549;
- **(iv)** Communicable disease information as defined and protected under ORS 433.008 and ORS 433.045(4);
- **(v)** Medical assistance records as defined and protected under 42 USC § 1396a(a)(7), 42 CFR § 431.300 to 431.307, and ORS 413.175;
- **(vi)** Other personal information as defined and protected under ORS 646A.600 to 646A.628;
- **(vii)** Educational records protected under FERPA and those protected under the Individuals with Disabilities Education Act;
- **(viii)** Child welfare records, files, papers, and communications provided for under ORS 409.225;
- **(ix)** Child abuse reports protected under ORS 419B.035;
- **(x)** Abuse records of adults with developmental disabilities or mental illness provided for under ORS 430.763;
- **(xi)** Elder abuse records and reports and any compilation thereof in accordance with ORS 124.090;
- **(xii)** Data provided to or created by or at the direction of a peer review body as defined and protected under ORS 41.675; and
- **(xiii)** Privileged communications as set forth under ORS 40.225 through ORS 40.295.

**"Provider"**[6] 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.

[6] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**"Provider Network"**[7] and **"Delivery System Network"**[8] and **"DSN"** each means the entirety of those Participating Providers who are employed by or Subcontracted with Contractor for the purposes of providing services to Members.

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

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

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

**"Quality 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.

**"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.

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

**"Records"** means all Clinical Records, financial records, other records, books, documents, papers, plans, records of shipments and payments, and writings of Contractor whether in paper, electronic or any other written form, that are pertinent to this Contract.

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

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

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

- **(i)** those report templates, reference documents, guidance documents, or other documentation referred to in the Contract,
- **(ii)** required or otherwise recommended to be used or referenced in performing the obligations or meeting the conditions of the Contract, and
- **(iii)** posted on or accessed through one or more webpages on OHA's website, including, without limitation, OHA's DCO Contract Forms Website.

**"Related Party"** means an entity that:

- **(i)** provides administrative services or financing to a DCO directly or through one or more unrelated parties; and
- **(ii)** is associated with the DCO by any form of affiliation, control or investment.

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

[7] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.
[8] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**"Renewal Contract"** means an amended and restated DCO Contract for the succeeding Contract Year that OHA submits to CMS for approval.

**"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.

**"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

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

**"Sanction"** means an action taken by Contractor against a Provider or Subcontractor, or by the Authority against Contractor, in cases of Fraud, Waste, Abuse, or violation of contractual requirements.

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

**"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.

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

**"Social Determinants of Health and Equity"** and **"SDOH-E"** each has the meaning provided for in OAR 410-141-3735.

**"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, Dental specialties include, without limitation, endodontics, periodontics, prosthodontics, pedodontics, orthodontics, and oral surgery.

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

**"State 1115 Waiver"** means the 1115 Waiver issued to Oregon by CMS on or about January 12, 2017, for the period ending June 30, 2022. 1115 waivers are issued by CMS in accordance with Section 1115 of the Social Security Act pursuant to which CMS waives federal guidelines relating to Medicaid in order to permit states, including Oregon to pilot and evaluate innovative approaches to serving Members. "State 1115 Waiver" does not include any waiver issued to Oregon by CMS specifically relating to the COVID-19 Emergency.

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

**"Subcontractor"**[9] has the meaning provided for in OAR 410-141-3500.

[9] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**"Subcontractor and Delegated Work Report"** means the Report required to be prepared by Contractor and submitted to OHA as set forth in Sec. 9, 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.

**"Successor DCO Contract"** means a DCO contract for the same or similar services as those provided under this Contract that OHA may, but it not obligated to, offer to enter into with Contractor for a twelve-month term commencing on January 1, 2023.

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

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

**"Teledentistry"** has the meaning provided for in OAR 410-123-1060.

**"Telehealth"** has the meaning provided for in OAR 410-120-1990.

**"Term"** means the one-year period that Contractor is required to provide services to Members under this Contract commencing on January 1, 2022, and expiring, unless earlier terminated in accordance with Sec. 1.1 of the General Provisions and as otherwise provided for in this Contract, December 31, 2022. Unless expressly stated otherwise, all terms and conditions of the Contract shall be applicable for its entire Term.

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

**"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.

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

**"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 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.

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

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

**"Tribe(s)"** means one or more of Oregon's nine federally recognized tribes and, as the context requires, includes Oregon's Urban Indian Health Program.

"**Triple Aim**" means the three goals of a Transformation and Quality Program as follows:

**(i)** providing better care to Members,

**(ii)** improving Member health, and

**(iii)** doing so at a lower cost

**"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.

**"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.

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

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

**(i)** Can be processed without obtaining additional information from the Provider of the service; and

**(ii)** Has been received within the time limitations prescribed in OAR 410-141-3565. 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 Dentally 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.

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

**"Welcome Packet"** means the materials required to be provided to new Members as set forth in OAR 410-141-3585.

**"Wholly Owned Supplier"** has the meaning provided in 42 CFR § 455.101.

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

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

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

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

## Exhibit B – Statement of Work

Contractor agrees to perform the Work in accordance with the terms, conditions, and specifications provided in this Contract, including the Statement of Work.

## Exhibit B – Statement of Work – Part 1 – RESERVED

***[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 Dentally 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 Dentally Appropriate determinations with respect to the Benefit Package for 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 of Health Services as provided in OAR 410-141-3830.

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

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

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

### 2. Provision of Covered Services

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

**b.** Contractor shall ensure all Dentally Appropriate Covered Services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Clients under Fee-for-Service and as set forth in 42 CFR § 438.210. Contractor shall also ensure that the Covered Services are sufficient in amount, duration, and scope as necessary to achieve, as reasonably expected, the purpose for which the services are furnished, which includes the following:

**(1)** The prevention, diagnosis, and treatment of a disease, condition, or disorder that results in health impairments or disability;

**(2)** The ability to achieve age-appropriate growth and development; and

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

**c.** Contractor shall create a written Utilization Management Handbook that sets forth Contractor's utilization management policies, procedures, and criteria for Covered Services. The UM Handbook must comply with the utilization control requirements set forth in 42 CFR Part 456.

**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 Dentally Appropriate services to any Member.

**e.** Contractor shall ensure that Dental necessity determination standards and any other quantitative or non-quantitative treatment limitations applied to Covered Services are no more restrictive than those applied to Fee-for-Service Covered Services, as required under 42 CFR § 438.210(a)(5)(i).

**f.** Contractor shall provide OHA with its UM Handbook for review and approval upon request, which shall be made to Contractor's Contract Administrator via Administrative Notice. Contractor shall provide OHA with its UM Handbook in the manner and to the location identified by OHA in its request. OHA will review Contractor's UM Handbook for compliance with this 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.

**3. Authorization or Denial of Covered Services**

**a.** Contractor shall draft a Service Authorization Handbook that sets forth Contractor's written policies and procedures that comply with 42 CFR § 438.210 and OAR 410-141-3835 to ensure consistent application of review criteria for authorization decisions. Contractor shall ensure processes allow for consultation with a requesting Provider for dental 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 Oral Health Care Professional who has appropriate clinical expertise in treating the Member's Oral Health condition or disease. 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, Oral Health condition, or disease;

**(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 and (b) the services furnished are sufficient in amount, duration, and scope as necessary to achieve, as reasonably expected, the purpose for which the services are furnished;

**(4)** 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;

**(5)** 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);

**(6)** In accordance with 42 CFR § 438.210(d)(1), Contractor shall provide notice to, in response to all standard Service Authorization Requests, the requesting Provider as expeditiously as the Member's Oral Health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of fourteen (14) additional calendar days if the Member or Provider requests an extension, or if Contractor justifies a need for additional information and can demonstrate that the extension is in the Member's interest. In the event Contractor cannot meet the fourteen (14) day 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. (6) 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. (6), Sec. 3, Ex. B, Part 2, to OHA or its designee;

**(7)** 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 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;

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

**(9)** 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. (9), 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, Dental care, or treatment options, including any alternative treatment that may be self-administered, that is Dentally 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.

**(10)** 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

**(11)** 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 accordance with 42 CFR § 438.102(a)(2), Contractor is not required, subject to compliance with this Para. c, Sec. 3, Ex. B, Part 2 of this Contract, to provide or reimburse for, or provide coverage of, a counseling or referral service if Contractor objects to the service on moral or religious grounds. If Contractor elects not to provide or reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds and such objection is not unlawful discrimination, Contractor shall include in its Service Authorization Handbook its policy for such election and include such policy in its Member Handbook, in accordance with 42 CFR § 438.10(g)(2)(ii)(A)-(B) and 42 CFR § 438.102(b)(2), how Members may otherwise obtain information from OHA about how to access such services when not provided by Contractor due to a moral or religious objection.

**(1)** If Contractor elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds Contractor shall provide OHA with Administrative Notice of its written policy as follows:

**(a)** Annually, no later than January 31;

**(b)** Upon any material changes (which may not be implemented by Contractor until approved in accordance with this Sec. 3, Ex. B, Part 2); and

**(c)** Any time, upon OHA request.

**(2)** Within thirty (30) days from the due date, or within thirty (30) days from the received date if after the due date, of Contractor's policy under Sub. Para (1) of this Para. c, Sec. 3, Ex.

B, Part 2 of this Contract, OHA will notify Contractor of the approval status of its policy; OHA will notify Contractor within the same period if additional time is needed for review. In the event OHA determines Contractor's policy under Sub. Para (1) of this Para. c, Sec. 3, Ex. B, Part 2 of this Contract does not comply with 42 CFR § 438.10 or any other Applicable Law, Contractor shall follow the process set forth in Sec. 5, Ex. D.

**(3)** Contractor shall furnish its policy of non-coverage, as approved in writing by OHA to:

**(a)** Potential Members before and during Enrollment; and

**(b)** Members thirty (30) days prior to the effective date of the policy with respect to any particular service (which is the date on which OHA provides written approval of such policy).

**4. Covered Service Component: Dental Urgent Care and Dental Emergency Services**

Without limiting Contractor's obligation to provide 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 coordination responsibilities stated above.

**a. Dental Urgent Care and Dental Emergency Services**

**(1)** Contractor may not require Prior Authorization for Dental Emergency Services nor limit what constitutes a Dental Emergency Condition on the basis of lists of diagnoses or symptoms.

**(2)** Contractor shall provide an after-hours call-in system adequate to triage Dental Urgent Care and Dental Emergency Service calls.

**(3)** As provided for in 42 CFR § 438.114, Contractor shall not deny and is required to pay for a claim for Dental Emergency Services provided outside of an emergency department or urgent care setting, regardless of whether the Provider that furnishes the services has a contract with Contractor.

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

**(5)** Contractor shall cover and pay for Dental Post-Stabilization Services, as provided for in 42 CFR § 438.114. Contractor is financially responsible for Dental 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 Dental Post-Stabilization services to an amount no greater than what Contractor would charge the Member for the services obtained within the Provider Network.

**(6)** Contractor's financial responsibility for Dental Post-Stabilization Services it has not pre-approved ends when the Member is discharged, consistent with the requirements of 42 CFR § 438.114.

**(7)** Contractor shall cover Dental 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 as Dentally Appropriate.

**(8)** A Member who has a Dental Emergency 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 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.

**(9)** Contractor shall not refuse to cover Dental Emergency Services based on any failure of a Provider or Fiscal Agent to notify a Member's Primary Care Dentist of the Member's screening and treatment within ten (10) days of presentation for Emergency Services, as specified in 42 CFR § 438.114.

**(10)** Contractor shall not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Dental Emergency Services, consistent with 42 CFR § 438.114.

## 5. Covered Service Components: Other Services

### a. Tobacco Cessation

Contractor shall provide Culturally and Linguistically Appropriate tobacco dependency and cessation services by developing and implementing evidence-based guidelines that reference accepted published standards for tobacco intervention in a dental office setting. As a minimum, Contractor's guidelines shall include the "2 A's and R" as outlined in Sub.Paras. (1-3) below.

**(1)** A = Ask patients about their tobacco-use status at each visit and record information in the chart;

**(2)** A = Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and

**(3)** R = Refer patients who are ready to quit utilizing internal and external resources to complete the remaining three A's (Assess, Assist, Arrange) of the standard intervention protocol for tobacco users.

**(4)** References:

(a) U.S. Center for Disease Control and Prevention's Brief Tobacco Intervention endorsed by the American Dental Hygienists' Association: https://www.cdc.gov/tobacco/basic_information/for-health-care-providers/patient resources/pdfs/70435-SF-AMA-Promo-IntCard-v2-508.pdf

(b) Gordon JS, Andrews JA, Lichtenstein E, Severson H. The impact of a brief tobacco-use cessation intervention in public health dental clinics. JADA 2005; 136:179-186

### b. 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, Divisions 123 and 141 applicable to Dental Care Organizations.

**(2)** Contractor shall establish written policies and procedures for Dental Emergency Services and for Dental Urgent Care Services for Oral Health conditions that are consistent with the access standards specified below, OAR 410-141-3515[10], and Ex. B, Pt. 4, Sec. 2. The policies and procedures must describe when treatment of a Dental Emergency Condition

[10] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

or a Dental Urgent Care Service should be provided in an ambulatory dental office setting and when Dental Emergency Services should be provided in a Hospital setting.

**(a)** For routine Oral Health care, the Member shall be seen within an average of eight (8) weeks and no more than twelve (12) weeks from the date of initial enrollment, unless there is a documented special clinical reason which would make access longer than eight weeks (8) appropriate. Routine Oral Health treatment or treatment of incipient decay does not constitute emergency care.

**(b)** For a Dental Emergency Service, the Member must be seen or treated within twenty-four (24) hours, and for a Dental Urgent Care Service, within one (1) to two (2) weeks or earlier[11] as indicated in the initial screening in accordance with OAR 410-123-1060. The treatment of a Dental Emergency Condition is limited to Covered Services. OHA recognizes that some Non-Covered Services may meet the criteria for treatment of for the Dental Emergency Condition; however, this Contract does not extend to those Non-Covered Services.

**(c)** For pregnant women, Contractor's policies and procedures shall comply with the access standards specified in OAR 410-123-1510.

**(3)** Contractor shall provide Preventive Services, which are those services promoting dental health and/or reducing the risk of disease or illness included under OAR 410-120-1210, Dental Assistance Benefit Packages and Delivery System, OAR 410-141-3820, Covered Services, and OAR 410-141-3830, Prioritized List of Health Services. Such services include, but are not limited to, periodic dental examinations based on age, gender and other risk factors; screening tests; and counseling regarding behavioral risk factors.

(a) Preventive services screening and counseling content is based on age and risk factors determined by a comprehensive patient history. Contractor shall provide all necessary diagnosis and treatment services identified as a result of such screening to the extent such services are Capitated Services. To the extent such services are not Capitated Services, but are Dental Case Management Services, Contractor shall refer the Member to an appropriate Participating or Non-Participating Provider and manage and coordinate the services.

(b) For Preventive Care Services related to Dental Services, provided through any Subcontractors (including, but not limited to, Federally Qualified Health Centers, 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 Dental Case Management and Record Keeping responsibilities.

(c) Contractor shall provide Dental Case Management Services which includes, without limitation, a comprehensive, ongoing assessment of dental needs related to dental health plus the development and implementation of a plan to obtain needed Dental Services that are Capitated Services or non-Capitated Services, and follow up, as appropriate to assess the impact of care.

(d) Contractor shall coordinate and manage all Capitated Services. Contractor shall document all referrals by Contractor or its Subcontractors to other Non-Participating Providers, whether or not the services are Capitated Services.

(e) Contractor shall implement procedures to share the results of its identification and assessment of any Member identified as aged, blind or disabled or having complex

[11] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

Dental needs with other MCEs serving the Member so that those activities need not be duplicated. Contractor shall create the procedures and share information under this Section 5, Ex. B, Part 3 in compliance with the confidentiality requirements of this Contract.

(f) Contractor shall comply with the mission, objectives, and guidelines of the Quality and Performance Improvement Workgroup. This includes, but is not limited to, specific prevention projects, both at the Contractor and State levels, collection and measurement of data, and regular intervals of data submissions.

**c. Telehealth and Teledentistry Services**

Contractor shall ensure that Telehealth and Teledentistry services meet all applicable requirements of OARs 410-120-1990 and 410-123-1265, including requirements relating to reimbursement, service delivery, patient choice and consent, access to care, and compliance with federal and state privacy and confidentiality rules.

**6. 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.

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

**a.** 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;

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

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

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

### 1. Member and Member Representative Engagement in Member Health Care and Treatment Plans

Contractor shall actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of Treatment Plans and Member dignity is respected. Contractor shall encourage Members to be responsible and active partners in the primary care team and shall protect Members against underutilization of services and inappropriate denial of services.

Contractor shall demonstrate how it:

**a.** Uses Community input 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.** Encourages Members to make healthy lifestyle choices and to use prevention and culturally-specific resources provided by Community-Based organizations and service Providers;

**d.** 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

**e.** 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 their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that Member has a right to report a complaint of discrimination by contacting Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights.

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

**d.** Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270.

**e.** Make OHA Certified or Qualified Health Care Interpreter services available free of charge to each Potential Member and Member. This applies to all non-English languages and sign language, not just those that OHA identifies as prevalent. Contractor shall notify its Members, Potential Members, and Provider Network that oral and sign language interpretation services are available free of charge for any spoken language and sign language and that written information is available

in Prevalent Non-English Languages in Service Area(s) as specified in 42 CFR § 438.10(d)(4). Contractor shall notify Potential Members and Members in its Member Handbook, Marketing Materials, and other Member materials, and its Provider Network in Contractor's new hire or other on-boarding materials and other communications, about how to access oral and sign language interpretation and written translation services.

**f.** Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Contractor's plan and develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3580 and 410-141-3585.

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

**i.** Allow each Member the right to: (i) be actively involved in the development of Treatment Plans if Covered Services are to be provided; (ii) participate in decisions regarding such Member's own health care, including the right to refuse treatment; (iii) have the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse Dental 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.

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

**r.** Contractor may use electronic communications for purposes described in Para. p above of this Sec. 2, Ex. B, Part 3 only if:

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

**(2)** The identical information is available in written, hard copy format upon request;

**(3)** The information does not constitute a direct notice related to an Adverse Benefit Determination or any portion of the Grievance, Appeal, Contested Case Hearing or any other Member rights or Member protection process;

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

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

**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 Oral Health Provider's opinions and counsel about the availability of Dentally 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.

**b.** Contractor shall, at least once every Contract Year, provide FBDE Members with written communications regarding Medicaid Oral Health benefits. Members who have not had accessed Oral Health benefits or had recommended preventive care shall be contacted by phone to alert

them to the opportunity to receive oral health care under their plan with Contractor. Where the FBDE member has a MA or Dual Special Needs Plan that offers Oral Health benefits, Contractor shall work with FBDE member's MA or Dual Special Needs Plan to develop specific communication.

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

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

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

**(2)** Be in English and translated into all other Prevalent Non-English Languages that align with Contractor's particular Service Area;

**(3)** Include language 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 PPACA 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 Contractor's website. If Contractor so chooses, all such Member information must be: (i) placed in a prominent and readily accessible location on such website; (ii) electronically retained or otherwise archived; and (iii) capable of being printed. Notwithstanding the availability of Member materials on Contractor's website, Contractor shall still make all such Member information available in paper form within five (5) days, without charge upon request by a Member or a Member Representative.

**(a)** In the context of Member materials, including, without limitation, Provider directories and Member Handbooks, "readily accessible" means electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

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

**(1)** The promotion and maintenance of optimal health status, to include identification of tobacco use, Referral for tobacco cessation intervention (e.g., educational material, tobacco cessation groups, pharmacological benefits and the Oregon Tobacco Quit Line (1-877-270-STOP)).

**e.** Contractor shall submit all Member notices, informational, educational materials, and Marketing Materials to OHA via SharePoint for review and approval by OHA's Quality Assurance (QA) unit: (i) prior to use and distribution to Members or any other third parties, unless an exception is granted by OHA in writing; or (ii) by a date certain when so identified in this Contract; and (iii) as may be requested by OHA or its designees from time to time.

**(1)** OHA's QA unit will provide written notice, via Administrative Notice to Contractor's Contract Administrator, of approval or disapproval of such submitted materials within 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 the DCO Contract Forms Website for guidance as to which materials do and do not require approval from OHA.

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

**f.** 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.

**g.** 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's QA unit via SharePoint for review and approval. Review and approval or disapproval shall be made in accordance with Para. e of this Sec. 4, Ex. B, Part 3.

**h.** 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. Notice of any such material changes shall be provided at least thirty (30) days prior to the intended effective date of those changes, or as soon as possible if the Participating Provider(s) has not given Contractor sufficient notification to meet

the thirty (30) day notice requirement.[12] But in no event shall the material changes take effect, and the applicable materials shall not be distributed or otherwise made available to Members and other third parties, until after Contractor has received approval of such changes from OHA's QA unit.

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

**a.** Contractor shall draft and provide each of its Members, and, if applicable, Potential Members with a Member Handbook that contains all of the information specified in the Member Handbook Evaluation Criteria located on the DCO 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 for review and approval: (i) Annually, not earlier than September 1 and not later than November 1, with any and all updates, new, or corrected information as needed to reflect Contractor's internal changes and any regulatory changes that will be in effect for the upcoming Contract Year; (ii) upon any material change prior to or after initial review and approval by OHA; and (iii) within five (5) Business Days after request by OHA as may be made from time to time. Member Handbooks shall be provided to OHA's Quality Assurance unit via SharePoint. 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)** Compliance with the Member Handbook Evaluation Criteria does not replace Contractor's obligation to satisfy 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 its OHA approved Member Handbooks available to Members within: (i) fourteen (14) days of receiving OHA's initial 834 listing of Member's Enrollment (or re-Enrollment after not being Enrolled for ninety (90) days or more) with Contractor and (ii) within fourteen (14) days of any other receipt of notice of a Member's Enrollment.

**(1)** Contractor may deliver the Member Handbook electronically if the Member has requested or approved electronic transmittal consistent with Sec. 2, Para. q above of this Ex. B, Part 3 of the Contract.

**(2)** Contractor shall notify all existing Members of each OHA approved revised Member Handbook and its location on Contractor's website. Existing Members are those Members

[12] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

to whom Contractor has not mailed its Member Handbook due to Enrollment or re-Enrollment 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 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.

**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, including Specialists, 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.

**d.** In order to be included in Contractor's Provider directory, Contractor's Providers, whether under contract directly with, or Subcontracted by, Contractor, must have agreed to provide the Covered Services or items to its 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)** Dentists, including Specialists; and

**(2)** Other licensed Oral Health Providers.

**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 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. e. and g. of Sec. 4 above of this Ex. B, Part 3.

**h.** Contractor shall develop and maintain written policies and procedures, criteria, and an ongoing process for managing the information flow, writing, and changing of Provider directories.

Contractor shall provide OHA with such policies, procedures, criteria, and processes as may be requested from time to time.

**i.** Contractor shall require its Participating Providers and Subcontractors to adhere to its established policies for Provider directories and the applicable timeframes for updating the information therein.

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

**7. Grievance and Appeal System**

**a.** 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**[13]

**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 DCO selected by the Member. If an eligible Member does not select a DCO, OHA may assign the Member to a DCO 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 DCO Coordinator, if and when Contractor's maximum Enrollment has been reached, or for any other reason mutually agreed to by OHA and Contractor, or as otherwise authorized under this Contract or OAR 410-141-3805.

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

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

[13] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

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

**h.** 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**[14]

The requirements and limitations governing Disenrollments contained in 42 CFR § 438.56 and OAR 410-141-3810 apply to Contractor regardless of whether Enrollment is mandatory or voluntary, except to the extent that 42 CFR § 438.56(c)(2)(i) is expressly waived by CMS. All Disenrollment requests and processes shall be made in compliance with the criteria set forth in OAR 410-141-3810.

**a.** An individual is no longer a Member for purposes of this Contract as of the effective date of the individual's Disenrollment from Contractor. As of that date, Contractor is no longer required to provide services to such individual by the terms of this Contract.

**b.** If Disenrollment occurs due to an illegal act which includes Member or Provider Medicaid Fraud, Contractor shall report to OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR § 455.13 by one of the following methods:

**(1)** Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or

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

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

**(1)** If requested orally or in writing by the Member or the Member Representative, OHA may Disenroll the Member in accordance with OAR 410-141-3810 for the reasons that are with and without cause.

**(2)** Subject to paragraph d., 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;

**(2)** Utilization of health services;

**(3)** Physical, intellectual, developmental, or mental disability;

**(4)** Uncooperative or disruptive behavior resulting from the Member's special needs, disability or any condition that is a result of their disability, unless otherwise permitted under;

**(5)** Being in the custody of DHS/Child Welfare;

**(6)** Prior to receiving any services, including, without limitation, anticipated placement in or Referral to a Psychiatric Residential Treatment facility;

**(7)** A Member's decision regarding their own Dental care with which Contractor disagrees; or

**(8)** Any other reasons that may be specified in OAR 410-141-3810.

[14] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency

**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 DCO 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 OHA's secure web portal, with Contractor's current Member information in its Health Information System for the same period (for purposes of this report refer to the previous month's data) which is known as a "look back period."

**b.** Contractor shall provide a report of Contractor's current Member information to OHA's Enrollment Reconciliation Coordinator using the Enrollment Reconciliation Certification Forms available on the DCO Contract Forms Website. Such report shall be submitted to OHA's Enrollment Reconciliation Coordinator using secure email. Contractor's determination of the OHA 834 monthly Enrollment transaction files shall be reported as follows:

**(1)** If there are no discrepancies between the OHA 834 monthly Enrollment transaction file with Contractor's current Member information as reported in Contractor's HIS, Contractor shall complete, sign, date and provide the "Enrollment Reconciliation Certification - No Discrepancies" form, to the OHA Enrollment Reconciliation Coordinator within fourteen (14) days of receipt of the OHA 834 monthly Enrollment transaction file, or

**(2)** If there are discrepancies between the OHA 834 monthly Enrollment transaction file with Contractor's current Member information as reported in Contractor's HIS, Contractor shall complete, sign, date and provide the "Enrollment Reconciliation Certification - Discrepancies Found" form, to the OHA Enrollment Reconciliation Coordinator within fourteen (14) days of receipt of OHA's monthly Enrollment transaction file.

**c.** OHA will verify, and if applicable, correct all discrepancies reported to OHA on "Enrollment Reconciliation - Discrepancies Found," prior to the next monthly Enrollment transaction file.

**12. Identification Cards**

Contractor shall provide an identification card to Members which contains simple, readable, and usable information on how to access care in an urgent or emergency situation consistent with OAR 410-141-3585. Such identification cards confer no rights to services or other benefits under the OHP and are solely for the convenience of the Members and Providers. Contractor shall refer to the Guidance Document

located on the DCO Contract Forms Website for the information to include on its Member identification card.

**13. Marketing to Potential Members**

**a.** In addition to Contractor's obligations with respect to Marketing Materials as set forth in Sec. 4 above of this Ex. B, Part 3, Contractor's Marketing Materials must comply with all the requirements set forth in 42 CFR § 438.104 and this Sec. 13, Ex. B, Part 3. Under no circumstances shall Contractor directly or indirectly engage in door to door, emailing, texting, telephone, or Cold Call Marketing activities.

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

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

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

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

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

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

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

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

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

**(1)** After Contractor's Contract Administrator has received approval from OHA of its proposed Marketing Materials, Contractor shall distribute copies of all written Marketing Materials to all DHS and OHA offices within Contractor's Service Area.

**e.** Contractor shall provide all proposed Marketing Materials to OHA's QA unit via SharePoint for review and approval by OHA prior to use and distribution. If the Marketing Materials submitted to OHA comply with the requirements under this Sec. 13, Ex. B, Part 3 and any other applicable provisions of the Contract, OHA will provide Contractor's Contract Administrator with Administrative Notice of approval. If, however, the Marketing Materials fail to comply with the requirements under this Sec. 13, Ex. B, Part 3 and any other applicable provisions of the Contract, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.

**f.** Contractor has sole accountability for producing or distributing Marketing Materials following OHA approval. After Contractor's Contract Administrator has received approval from OHA of its proposed Marketing Materials, Contractor shall distribute copies of all written Marketing Materials to all DHS and OHA offices within Contractor's Service Area.

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

### 1. Coordination and Continuity of Care

Contractor shall provide coordination and continuity of care in accordance with 42 CFR § 438.208 and as specified by OHA.

**a.** Contractor shall conduct an initial Oral Health risk screening of each new Member's needs. Upon initial Enrollment with Contractor, a Member's Oral Health risk screening must be completed and documented as quickly as the Member's health condition requires but (i) in no event more than ninety (90) days after the effective date of Enrollment, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful; or (ii) sooner than the timeframes required by the foregoing (i) if required by the Member's health condition. Contractor shall maintain documentation on the Oral Health risk screening process used for compliance. If the Oral Health risk screening requires additional information from the Member, Contractor shall document all attempts to reach the Member by telephone and mail, including subsequent attempts, to demonstrate compliance.

**b.** Contractor must share with, as applicable, the Primary Care Dentist (PCD), OHA, or other MCEs serving the Member the results of the Oral Health Screening identifying the Member's needs to prevent duplication of those activities.

**c.** Contractor shall ensure, and shall implement procedures to ensure, that in coordinating care, the Member's privacy is protected consistent with the confidentiality requirements in 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E, to the extent that they are applicable, and consistent with other Applicable Law.

**d.** 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 Contractor, its Oral Health care Providers, and the services a Member receives from community and social support providers.

**(2)** As applicable, DHS Area Agency on Aging/Aging and People with Disabilities Offices or Office of Developmental Disability Services case managers, and Providers who provide services to:

**(a)** Members receiving Long Term Care or Home and Community Based Services; and

**(b)** Members with developmental disabilities who receive services through Community developmental disability programs and organizations.

**(3)** Implementing integrated Prevention and Early Intervention, developing and implementing infrastructure and support for sharing information, coordinating care, and Monitoring results;

**(4)** Using screening tools, treatment standards, and guidelines that support integration; and

**(5)** Supporting a shared culture of integration across DCOs, CCOs, and service delivery systems.

**e.** Contractor shall coordinate the services Contractor furnishes its Members with the services the Member receives from any other MCE or OHA's FFS Medicaid program.

**f.** Contractor must ensure that each Member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the

services accessed by the Member. The Member must be provided information on how to contact their care coordinator or other designated person or entity

**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 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 42 CFR § 438.206, OAR 410-141-3515[15], and 410-141-3860[16]. Contractor shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week, when Dentally Appropriate. Contractor shall prioritize timely access to care for priority populations as set forth in this Ex. B, Part 4. Access to care must be provided to certain Members as follows:

**(1)** Pregnant women shall be seen with twenty-four (24) hours for emergency dental care or within 28 days (4 weeks) for routine dental care in accordance with OAR 410-123-1510.

**(2)** Contractor shall have a mechanism in place to allow Members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the Member's Oral Health condition and identified needs. Contractor shall ensure the services supporting Members with special health care needs are authorized in a manner that reflects the Member's ongoing need for such services and supports and do not create a burden to Members needing Oral Health medications or services to appropriately care for chronic conditions. For Members with special health care needs, Contractor shall coordinate with the care coordination contractor specified by OHA to identify Oral Health services requiring direct access. This mechanism is intended to meet the CMS goal to reduce duplication of efforts with other Providers and community partners and in improving outcomes for Members with special health care needs.

**b.** As required by Ex. G, Contractor shall report any 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.** If Contractor is unable to provide any Covered Services which are culturally, linguistically, and Dentally Appropriate to a Member within its Provider Network, then Contractor shall:

**(1)** Adequately and timely cover the services for the Member using Non-Participating Providers for as long as Contractor's Provider Network is unable to provide the services; and

**(2)** Coordinate payment with Non-Participating Providers.

**d.** Contractor shall ensure Members are seen, treated or referred within the timeframes in OAR 410-141-3515.[17]

**e.** 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

[15] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.
[16] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.
[17] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

Providers offer hours of operation to Members that are no less than those offered to non-Members as provided in OAR 410-141-3515. Contractor must have a mechanism to ensure compliance with timely access standards and hours of operation through secret shopper monitoring; monitor network providers regularly to determine compliance; and take corrective action if a network provider fails to comply with access requirements.

**(1)** Contractor must have a written policy and procedure in place to ensure compliance with timely access standards and provide such policy and procedure to OHA upon request.

**f.** Contractor does not have the right to, and shall not, deny Covered Services to, or request Disenrollment of, a Member based on uncooperative or disruptive behavior resulting from his or her special health care needs (except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees). Contractor shall develop appropriate Treatment Plans with such Members and their Families or advocates to manage such behavior.

**g.** Contractor shall comply with the requirements of Title II of the Americans with Disabilities Act and Title VI of the Civil Rights Act by assuring communication and delivery of Covered Services to Members with diverse cultural and ethnic backgrounds. Such communication and delivery of Covered Services in compliance with such Acts may also require, without limitation, Certified or Qualified Health Care Interpreter services for those Members who have difficulty communicating due to a medical condition, disability, or limited English proficiency, or where no adult is available to communicate in English, or there is no telephone and providing access to auxiliary aids and services. Contractor shall maintain written policies, procedures, and plans in accordance with the requirements of OAR 410-141-3515.

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

**i.** Contractor shall ensure that its employees, Subcontractors, and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency.

**j.** 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.

**k.** In addition to access and Continuity of Care standards specified the applicable OARs, Contractor shall develop a methodology for evaluating access to Covered Services as described in Ex. G of this Contract and Continuity of Care standards which are consistent with the Accessibility requirements in OAR 410-141-3515 and 42 CFR § 438.208.

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

**(2)** Using the Language Access reporting template located on the DCO Contract Forms Website, Contractor shall collect and report language access and interpreter services to OHA. The Report shall be provided to OHA quarterly with monthly detail, via Administrative Notice, on the third Monday of the months of January, April, July, and October for the preceding calendar quarter.[18]

[18] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**l.** Contractor shall confirm and document with the PCD's name and contact information in the patient's record that each Member has an ongoing source of primary care, as applicable to Dental services, appropriate to the Member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished as described in OAR 410-141-3860[19] and required by 42 CFR 438.208 (b)(1) and (2).

**m.** Contractor shall offer contracts to all Medicaid eligible IHCPs in its Service Area and provide access to specialty and primary care within its networks to DCO-enrolled Indian Health Services beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted Provider within Contractor's network.

**n.** Contractor shall allow all AI/AN Members enrolled with Contractor to choose such IHCP as their PCD if:

**(1)** An Indian Health Care Provider is participating as a PCD within the Provider Network; and

**(2)** The AI/AN Member is otherwise eligible to receive services from such Indian Health Care Provider; and

**(3)** The Indian Health Care Provider has the capacity to provide primary care Dental services to such Members.

**o.** In the event Contractor is unable to provide local access to care by Providers sufficiently qualified and specialized to treat a Member's condition, Contractor must demonstrate such inability and provide reasonable alternatives to care in accordance with OAR 410-141-3515 and 42 CFR § 438.206.

**p.** Contractor shall ensure that a Provider:

(1) Complies with the requirements of Enrolled Oregon House Bill 2359 (2021) regarding health care 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.

## 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 and Ex. B, Part 4 of this Contract) and has sufficient capacity and expertise to provide access to adequate and timely Dentally Appropriate 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 covered 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

[19] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

Network, Contractor shall develop and implement a methodology to establish and Monitor Provider Network capacity based, on at a minimum, the following factors:

**(a)** The anticipated Medicaid Enrollment and anticipated Enrollment of FBDE individuals;

**(b)** An appropriate range of preventive and specialty services for the population enrolled or expected to be enrolled in the Service Area;

**(c)** The expected utilization of Services;

**(d)** The number and types (in terms of training, experience, and specialization) of Providers required to provide services under this Contract;

**(e)** The geographical location[20] and distribution, as required under ORS 414.609, of Participating Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities;

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

**(g)** Data collected from Contractor's Monitoring of Member wait time to appointment;[21]

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

**(i)** The Provider Network is sufficient in numbers and areas of practice and geographically distributed in a manner that the Covered Services provided under this Contract are reasonably accessible to Members, as stated in ORS 414.609; and

**(j)** The number of Providers who are not accepting new Members.

**(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 Oral Health 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 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 and pregnant women.

## 4. Provider Selection

Contractor shall establish written policies and procedures that comply with credentialing and re-credentialing requirements outlined in OAR 410-141-3510, the requirements specified in 42 CFR § 438.214, which include selection and retention of Providers and nondiscrimination provisions.

**a.** In establishing and maintaining the network, Contractor shall:

[20] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.
[21] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**(1)** Complete and provide OHA with DSN Provider 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; and

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

**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, Para. 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 Dentists, Specialists, and other related Dental professionals used to deliver Covered Services, consistent with PPACA Section 6402, 42 CFR § 438.214, 42 CFR § 455.400-455.470 (excluding § 455.460), OAR 410-141-3510 and 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 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.

**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 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.

**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 Dentist 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. 11, Para. b, Sub. Para. (8) 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. Care Coordination

In compliance with 42 CFR § 438.208, Contractor shall provide all of the elements of Oral Health care coordination on behalf of its Members as set forth below in this Section. Accordingly, Contractor shall do all of the following:

**a.** Support the appropriate flow of relevant information to manage Member care and, in the absence of full health information technology capabilities, implement a standardized approach to effectively plan, communicate, and implement transition and care planning and follow-up;

**b.** With support from OHA, work with Providers to develop the partnerships necessary to allow for access to, and coordination with, community and social and support providers;

**c.** Develop Culturally and Linguistically Appropriate tools that Providers may use to assist in educating Members about roles and responsibilities in communication and Care Coordination;

**d.** Use Evidence-Based and innovative strategies within Contractor's delivery system to ensure coordinated and integrated person-centered care for all Members, including those with severe and persistent mental illness, special health care needs, or other chronic conditions, who receive home and Community-Based services under Section 1915(i), the States Plan Amendment, or any Long Term Services and Supports through DHS

**e.** Encourage and work with its 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.

**f.** Provide:

**(1)** Adequate and appropriate access to dental Providers for covered Oral Health services; and

**(2)** Adequate, timely and appropriate payment for specialty and Outpatient Hospital/ASC Provider services. Contractor's service agreements with specialty and Outpatient Hospital/ASC Providers must:

**(a)** Address the coordinating role of patient-centered oral health care;

**(b)** Specify processes for requesting Outpatient Hospital/ASC admission or specialty services; and

**(c)** Establish performance expectations for communication and Dental records sharing for specialty treatments: (x) at the time of Outpatient Hospital/ASC admission or (y) at the time of Hospital/ASC discharge for the purpose of facilitating after Outpatient Hospital/ASC follow up appointments and care.

**g.** 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 an Oral Health care team that is responsible for comprehensive care management and transitions;

**(2)** Had their supportive and therapeutic needs addressed in a holistic fashion, using individualized care plans to the extent feasible;

**(3)** Received assistance in navigating the health care delivery system; and

**(4)** Received Oral Health risk screenings, as appropriate.

**7. Delivery System Dependencies**

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

**(1)** Contractor shall prioritize working with communities experiencing health disparities in accordance with OAR 410-141-3870. Contractor shall actively engage such Members in accessing and managing appropriate preventive, remedial, and supportive care and services to reduce the use of avoidable Emergency Department visits with an Oral Health condition as the primary diagnosis.

**(2)** Contractor shall create procedures and share information (e.g., via HIE or regularly scheduled interdisciplinary or multidisciplinary care conferences) for the purposes permitted under ORS 414.607 and subject to the information security and confidentiality requirements set forth therein as well as any other confidentiality and information security requirements of this Contract and other Applicable Laws.

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

**(1)** Contractor shall coordinate services for each Member who requires Dental assistance services not covered under the Capitation Payment. As applicable, and with support from OHA, Contractor shall arrange, coordinate, and monitor Non Capitated Services for Dental care for each such Member on an ongoing basis.

**(2)** Contractor shall document its professional relationships with Local or Regional Allied Agencies, as defined in OAR 410-120-0000, Community Emergency Service agencies,

and local Non-Participating Providers which may offer services that are not Covered Services under the Capitation Payment.

**c. Cooperation with Physical Care Providers**

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

## 8. 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.

## 9. Subcontract Requirements

Contractor's Subcontracts, including those entered into with Participating Providers that meet the definition of a Subcontractor, must comply with the requirements set forth in this Sec. 9 of Ex. B, Part 4. However, nothing in this Sec. 9 precludes Contractor from including additional terms and conditions in its Subcontracts provided that such additional terms and conditions do not conflict with or otherwise amend the requirements set forth herein and as otherwise required under this Contract. In no event shall Contractor Delegate or otherwise assign to third parties the responsibility for performing any Work required under this Contract without first entering into a Subcontract that complies with the terms and conditions of this Contract. In all such instances, Contractor shall, at a minimum, comply with all of the following:

**a. General Standards**

**(1)** To the extent Contractor Subcontracts any services or obligations to a Subcontractor, Subcontractor must perform the services and meet the obligations and terms and conditions as if the Subcontractor is the Contractor.

**(2)** Contractor shall ensure that all Subcontracts: (i) are in writing; (ii) specify the Subcontracted Work and reporting responsibilities; (iii) are in compliance with the requirements described below in this Sec. 9, 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 Medicare, but only for Work identical to that to be Subcontracted under this Contract and only if the Medicare readiness review has been completed no more than six (6) months 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 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. 9, Ex. B, Part 4, Contractor may Subcontract obligations and Work required to be performed under this Contract that is not expressly identified as an exclusion. In accordance with 42 CFR § 438.230(b)(1), no Subcontract may terminate or limit Contractor's legal responsibility to OHA for the timely and effective performance of Contractor's duties and responsibilities under this Contract. A breach of the requirements of this Contract by a Subcontractor shall be deemed a breach of Contractor and Contractor shall be liable for such Subcontractor breach. The imposition of any and all Corrective Action, Sanctions, Recoupment, Withholding, and other recovered amounts and enforcement actions against any Subcontract is solely the responsibility of Contractor. Contractor retains all legal responsibility and shall not have the right to Subcontract the responsibility for Monitoring and oversight of Subcontracted activities.

**(8)** Contractor shall provide to OHA, via Administrative Notice, a Subcontractor and Delegated Work Report in which Contractor shall summarize in list form all Work and other activities required to be performed under this Contract that have been Subcontracted to a Subcontractor. The Subcontractor and Delegated Work Report must be provided to OHA by no later than January 31 of each Contract Year and within thirty (30) days after there has been any change in a Subcontractor or the Work Delegated to such Subcontractor. The Subcontractor and Delegated Work Report shall also include all of the following:

**(a)** The legal name of the Subcontractor;

**(b)** The scope of Work being Subcontracted;

**(c)** Copies of ownership disclosure form, if applicable;

**(d)** Any ownership stake between Contractor and the Subcontractor; and

**(e)** An attestation that Contractor has (i) conducted a readiness review of the Subcontractor, 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; (ii) confirmed that the Subcontractor was and is not an excluded from participation in federal program; (iii) confirmed all Subcontractor employees are subject to, and have undergone, criminal background checks; and (iv) that the written Subcontract entered into with the Subcontractor meets all of the requirements set forth in this Ex. B, Part 4 and other applicable provisions of this Contract.

**(9)** In addition to the obligations identified as being precluded from Subcontracting under this Sec. 9, 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 perform, at least once a year, a formal review of compliance with all Subcontracted obligations and other responsibilities, performance, deficiencies, and areas for improvement. Such review shall be documented in an Annual Subcontractor Performance Report, which must be completed within one hundred eighty (180) days after the annual anniversary of the effective date of the Subcontract. Contractor shall make a conclusion in each Annual Subcontractor Performance Report as to whether a Subcontractor has complied with all the terms and conditions of this Contract that are applicable to the Work performed by Subcontractor.

**(14)** The Annual Subcontractor Performance Report must include at a minimum the following elements:

**(a)** An assessment of the quality of Subcontractor's performance of contracted Work;

**(b)** Any complaints or Grievances filed in relation to Subcontractor's Work;

**(c)** Any late submission of reporting deliverables or incomplete data;

**(d)** Whether employees of the Subcontractor are screened and Monitored for federal exclusion from participation in Medicaid;

**(e)** The adequacy of Subcontractor's compliance functions; and

**(f)** Any deficiencies that have been identified by OHA related to work performed by Subcontractor.

**(15)** 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. 9 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 Annual Subcontractor Performance Report required to be submitted under this Contract.

**(16)** Contractor shall provide a copy of each Annual Subcontractor Performance Report (or the substituted Medicare Compliance Review) to OHA, via Administrative Notice, within thirty (30) days of completion. Contractor shall oversee and be responsible for the satisfactory performance of any functions or responsibilities it has Delegated to a Subcontractor.

**(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 Subcontractor to implement a Corrective Action Plan to remedy such deficiencies. In addition, Contractor shall provide to OHA, via Administrative Notice, a copy of the CAP documenting the deficiencies, actions required of the Subcontractor to remedy the deficiencies, and the time frame for completing such required actions. The foregoing Administrative Notice shall be made within fourteen (14) days after providing the Corrective Action Plan to the applicable Subcontractor.

**(18)** Contractor shall provide OHA with an update on the status of the Corrective Action Plan at such time that the Subcontractor has (i) been successfully removed from Corrective Action, or (ii) of the Subcontractor's failure to fully remedy the underlying deficiency if the deadline for such remedy has passed. Such update shall be provided to OHA, via Administrative Notice, within fourteen (14) days after the intended original completion date set forth in the applicable CAP.

**b. Requirements for Written Agreements with Subcontractors**

**(1)** Contractor shall include in all of its Subcontracts with its Subcontractors all of the following:

**(a)** Provide for termination of the Subcontract, the right to take remedial action, and impose other Sanctions by Contractor, such that Contractor's rights substantively align with OHA's rights under this Contract, if the Subcontractor's performance is inadequate to meet the requirements of this Contract;

**(b)** Provide for revocation of the delegation of activities or obligations, and specify other remedies in instances where OHA or Contractor determine the Subcontractor has breached the terms of the Subcontract;

**(c)** Require Subcontractor to comply with the payment, withholding, incentive, and other requirements set forth in 42 CFR § 438.6 that are applicable to the Work required under the Subcontract;

**(d)** Require Subcontractors to submit to Contractor Valid Claims for services including all the fields and information needed to allow the claim to be processed without further information from the Provider within timeframes for valid, accurate, Encounter Data submission as required under Ex. B, Part 8 and other provisions of this Contract;

**(e)** An express statement whereby Subcontractor agrees to comply with all Applicable Laws, including, without limitation, all Medicaid laws, rules, regulations, as well as all applicable sub-regulatory guidance and contract provisions;

**(f)** An express statement whereby Subcontractor agrees that OHA, the Oregon Secretary of State, CMS, HHS, the Office of the Inspector General, the Comptroller

General of the United States, or their duly authorized representatives and designees, or all of them or any combination of them, have the right to audit, evaluate, and inspect any books, Records, contracts, computers or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract;

**(g)** Specify that the Subcontractor will make available, for purposes of audit, evaluation, or inspection its premises, physical facilities, equipment, books, Records, contracts, computer, or other electronic systems relating to its Medicaid Members;

**(h)** Specify that the Subcontractor must respond and comply in a timely manner to any and all requests from OHA or its designee for information or documentation pertaining to Work outlined in this Contract;

**(i)** Specify that the Subcontractor agrees that the right to audit by OHA, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist for a period of ten (10) years from this Contract's Expiration Date or from the date of completion of any audit, whichever is later;

**(j)** Specify that if OHA, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, OHA, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time;

**(k)** 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 Clinical Records 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 applicable OARs, 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. 12, Ex. B, Part 8 of this Contract; and

**(o)** Require Subcontractors to provide, in a timely manner upon request, as requested by Contractor in accordance with the request made by OHA, or as may be requested directly by OHA, with all Third Party Liability eligibility information and any other information requested by OHA or Contractor, as applicable, in order to assist in the pursuit of financial recovery.

**(2)** In the event Contractor issues or receives notice that a Subcontractor's Subcontract has been terminated, Contractor shall provide, within fifteen (15) days after receipt or issuance of the termination notice, written notice of such termination to the Members who received regular care or primary care from the terminated Subcontractor.

**(3)** Contractor shall have thirty (30) days to provide OHA with Administrative Notice that: (i) it has terminated a Subcontractor, or (ii) a Subcontractor has terminated its Subcontract with Contractor. Such Administrative Notice shall also include an updated 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, which may be made, via Administrative Notice, to Contractor's Contract Administrator, Contractor shall provide OHA with any and all copies of Subcontracts entered into by Contractor that relate to the services required to be provided under this Contract. Such Subcontracts shall be provided to OHA in the manner directed by OHA in its request.

**10. Minority-Owned, Woman-Owned and Emerging Small Business Participation**

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

**b.** Contractor shall take reasonable steps, such as through a quote, bid, proposal, or similar process, to ensure that MWESB certified firms are provided an equal opportunity to compete for and participate in the performance of any Subcontracts under this Contract. If there may be opportunities for Subcontractors to work on the Contract, it is the expectation of OHA that Contractor will take reasonable steps to ensure that MWESB certified firms, as referenced on: https://www.oregon4biz.com/How-We-Can-Help/COBID/.

## 11. Adjustments in Service Area or Enrollment

**a.** If Contractor is engaged in the termination or loss of a Provider or group or affected by other factors which have significant impact on access in that Service Area and which may result in transferring a substantial number of Members to other Providers employed by or Subcontracted with Contractor, Contractor shall provide to OHA, via Administrative Notice, a written plan for transferring the Members and an updated DSN Provider Report, as required under 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.

**c.** OHA will not approve a transfer of Members if the Provider's contract with the transferring DCO is terminated for reasons related to quality of care, competency, Fraud or other reasons described in OAR 410-141-3810.

**d.** OHA reserves the right to waive or otherwise amend the required time period in which Administrative Notice is required to be provided to OHA relating to the termination or loss of a Provider, Provider group, or Service Area, including but not limited to:

**(1)** If Contractor shall terminate a Provider or group due to circumstances that could compromise Member care;

**(2)** If a Provider or group terminates its Subcontract or employment with Contractor or if Contractor is affected by circumstances beyond Contractor's control and the Contractor cannot reasonably provide the required ninety (90) day notice; or

**(3)** At OHA's discretion.

**e.** OHA will reassign any transferring Members to another Managed Care Entity in the Service Area with sufficient capacity or may seek other avenues to provide services to Members.

**f.** Contractor retains responsibility for ensuring sufficient capacity and solvency and providing all Covered Services through the end of the ninety (90) day transition period to all Members for which Contractor received a DCO Payment.

**g.** If Members are required to Disenroll from Contractor pursuant to this Sec. 11, 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. 11, Ex. B, Part 4 of this Contract. OHA shall have the right, in its discretion, to withhold up to 20% of Contractor's monthly DCO Payment (subject to actuarial considerations) until all contractual obligations under this Contract have been met to OHA's satisfaction. Contractor's

failure to complete or ensure completion of said contractual obligations within a timeframe defined by OHA will result in a forfeiture of the amount withheld.

**i.** If Contractor is assigned or transferred Clients pursuant to this section, Contractor accepts all assigned or transferred Clients without regard to the Enrollment exemptions in OAR 410-141-3805.

**j.** If this Contract is amended to reduce the Service Area or the Enrollment limit, or both, OHA may recalculate the DCO 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 DCO 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 DCO 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 DCO 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, Dental 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, 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. 14 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 Dentally Appropriate services consistent with the documented needs of the Member;

**(2)** Conforms to accepted professional practice and any and all Applicable Laws related thereto;

**(3)** Is supported by written policies and procedures; and

**(4)** Allows Contractor to ensure that data received from Providers is accurate and complete by:

**(a)** Verifying the accuracy and timeliness of reported data;

**(b)** Screening the data for completeness, logic, and consistency; and

**(c)** Collecting service information in standardized formats.

**f.** Contractor shall review all of its internal record keeping policies and procedures on a biennial basis or as required by other sections in this Contract.

**g.** Contractor shall inform OHA if it has been accredited by a private independent accrediting entity. If Contractor has been so accredited, Contractor shall authorize the private independent accrediting entity to provide OHA a copy of its most recent accreditation review, including:

**(1)** Accreditation status, survey type, and level (as applicable);

**(2)** Accreditation results, including recommended actions or improvements, Corrective Action Plans, and summaries of findings; and

**(3)** Expiration date of the accreditation.

**2. Privacy, Security, and Retention of Records; Breach Notification**

**a.** In accordance with OAR 410-141-3520 Contractor's record keeping system must ensure the security of its Records, including Clinical Records that document the Covered Services provided to Members, as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing HIPAA. Contractor shall have written policies and procedures regarding the access, use, and transmission of records that comply with ORS 413.171, OAR 943-014-0300 through 943-014-0320, OAR 943-120-0000 through 943-120-0200, and this Sec. 2, of this Ex. B, Part 8. Contractor shall also allow OHA to Monitor compliance with Contractor's Records Security Policies.

**b.** In accordance with OAR 410-141-3520, Members must have access to their own personal health information in the manner provided in 45 CFR § 164.524 and ORS 179.505(9) so the Member can share the information with others involved in the Member's care and make better health care and lifestyle choices. Contractor and its Participating Providers may charge Members for reasonable duplication costs when they request copies of their records.

**c.** Pursuant to ORS 414.607(3) and notwithstanding ORS 179.505, Contractor and its Provider Network, shall use and disclose Member information for purposes of service and care delivery, coordination, service planning, transitional services, and reimbursement, in order to improve the safety and meet the Triple Aim goals of providing quality of care, lowering the cost of care, and improving the health and well-being of the Members.

**d.** Pursuant to ORS 414.607(4) Contractor and its Provider Network shall use and disclose sensitive diagnosis information, including HIV and other health and mental health diagnoses, for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.553 to 192.581 and all other Applicable Laws relating to health information privacy. Redisclosure of individually identifiable information outside of Contractor's organization and its Provider Network for purposes unrelated to this section or the requirements of ORS 414.572, 414.632, 414.605, 414.638, 414.598 or 414.655 is only permitted in accordance with Applicable Laws relating to health information privacy.

**e.** Pursuant to ORS 413.175 and OAR 943-014-0010(3) and (4), Contractor and its Provider Network may disclose information about Members to OHA and DHS for the purpose of administering the laws of Oregon.

**f.** In the event Contractor Discovers 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@dhsoha.state.or.us, 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. 14 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 PPACA regarding the use of National Correct Coding Initiative.

**e.** Certain federal laws governing reimbursement of services provided by Federally Qualified Health Centers, Rural Health Centers, and Indian Health Care Providers may require OHA to provide supplemental payments to those entities, even though those entities have Subcontracted with Contractor to provide Covered Services. This may also be the case with IHCPs who have not entered into Subcontracts with Contractor. These supplemental payments are outside the scope of this Contract and do not violate this Contract's prohibition on dual payments. Contractor shall maintain Encounter Data records and any other information relating thereto documenting Contractor's reimbursement to FQHCs, Rural Health Centers, and IHCPs, and provide such information to OHA upon request. Contractor shall also provide information documenting Contractor's reimbursement to non-participating IHCPs to OHA upon request.

**f.** Consistent with 42 CFR § 438.106 and 42 CFR § 438.230, Contractor shall prohibit Subcontractors, including Providers, from billing Members for Covered Services in any amount greater than would be owed if Contractor provided the services directly. 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(3)(h) prior to providing any of the Non-Covered Services.

**h.** Contractor shall reimburse Providers for all Covered Services delivered in integrated clinics by Health Care Professionals and other Providers.

**i.** Contractor shall support a Warm Handoff of a Member between levels or Episodes of Care.

**5. Claims Payment**

**a.** Claims that are subject to payment under this Contract by Contractor for services provided by Non-Participating Providers who are enrolled with OHA will be billed to Contractor consistent with the requirements of OAR 410-120-1280, 410-120-1295, and 410-120-1300. Contractor shall pay Non-Participating Providers for Covered Services, consistent with the provisions of ORS 414.743, OAR 410-120-1295(2), OAR 410-120-1340, and OAR 410-141-3565.

**b.** Pursuant to OAR 410-141-3565, Contractor shall require Providers to submit all claims for Members to Contractor within 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 141-120-1560; 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 (i) enrolled with Contractor as AI/AN and (ii) are eligible to receive services from such Providers. Payment to IHCP for Covered Services shall be made as follows:

**(1)** Participating IHCPs are paid at a rate equal to the rate negotiated between Contractor and the Participating Provider involved, which for a FQHC may not be less than the level and amount of payment which Contractor would make for the services if the services were furnished by a Participating Provider which is not a FQHC.

**(2)** Non-Participating IHCPs that are not a FQHC must be paid at a rate that is not less than the level and amount of payment which Contractor would make for the services if the services were furnished by a Participating Provider which is not an Indian Health Care Provider.

**(3)** Non-Participating IHCPs that are a FQHC must be paid at a rate equal to the amount of payment that Contractor would pay a FQHC that is a Participating Provider with respect to Contractor but is not an IHCP for such services.

**h.** 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.

**i.** 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.

**j.** Contractor shall pay for Dental Emergency Services provided by Non-Participating Providers, as specified in OAR 410-141-3840.

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

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

**(2)** Require all Providers to identify Provider-Preventable Conditions that are associated with claims for DCO Payment or with courses of treatment furnished to Members for which DCO 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 and dental literature by qualified professionals, to be reasonably preventable through the application of procedures supported by Evidence-Based guidelines;

**(c)** Has a negative consequence for the Member;

**(d)** Is auditable; and

**(e)** Includes, at a minimum, incorrect surgical or other invasive procedures performed on a Member; surgical or other invasive procedures performed on the wrong body part; surgical or other invasive procedures performed on the wrong Member.

**6. Medicare Payers and Providers**

**a.** As applicable, Contractor shall coordinate with any and all Medicare payers and Providers as Dentally Appropriate to coordinate Member access to Covered Services, Care Coordination, care delivery, and other benefits of Members who are eligible for both Medicaid and Medicare. This includes both: (i) the coordination of services Members receive from any MCE, Medicare payers, Medicare Providers, and Medicaid-Funded Long Term Services and Supports in order to avoid duplication of services as required under 42 CFR §438.208(b)(2) and (5), and (ii) the participation in the development of integrated treatment, care planning, and transition of care as may be necessary. Medicare coverage of Oral Health care services is limited. Consequently, in accordance with OAR 410-141-3565, Contractor shall not require Providers to bill Medicare directly as the primary insurer for services or items known not to be covered by Medicare, nor shall Contractor require non-Medicare approved Providers to bill Medicare.

b. Contractor shall be responsible for Medicare deductibles, coinsurance and co-payments in accordance with the State's methodology up to Medicare's or Contractor's allowable amounts for all Oral Health care services and Oral Health care auxiliary Medicare Part and Part B for Covered Services that Contractor's Medicare eligible Members receive from a Medicare Provider (who is either a Participating Provider, or a Non-Participating Provider, if authorized by Contractor or Contractor's representatives, or for Dental Emergency Services or Dental Urgent Care Services) after adjudication with the applicable Medicare or Medicare Advantage Plan.

**(1)** Contractor shall ensure its Providers are notified of proper billing processes for crossover claims consistent with the State's Qualified Member Beneficiary Program regulations under the Social Security Act and OAR Chapter 461 or Covered Services. Contractor's Providers shall not bill a Member for Non-Covered Services unless the Provider complied with the requirements set forth OAR 410-120-1280(3)(h) prior to providing any of the Non-Covered Services.

**(2)** For FBDE Members, Contractor shall ensure providers either implement a process by which Medicare Providers either complete a pre-service coverage determination through the MA or DSN Plan or complete a Medicare Advance Beneficiary Notice of Noncoverage Form when services are not covered by Medicare. These steps ensure members are aware that services being recommended are not covered and would result in member out-of-pocket costs prior to provision of any Non-Covered services.

**c.** Providers must be enrolled with Oregon Medicaid to receive cost sharing payments. Contractor is encouraged to provide non-enrolled Providers with information about enrolling with Oregon Medicaid to receive sharing payments.

**d.** Contractor shall ensure its Provider Network is adequate to provide Medicaid services to FBDE Members even when an MA or DSN Plan is the primary payer. In the event Contractor's Provider

Network, or a Member's Medicare Advantage or DSN plan does not comply with the timely access to care standards required under this Contract, Contractor shall:

(1) Provide Members with timely 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

(2) In accordance with 42 CFR §422.112(a)(2), make other arrangements to ensure access to Dentally necessary specialty care if referrals from PCDs are required but Contractor's Provider Network is not adequate to enable its FBDEs to select a PCD.

**7. Eligibility Verification for Fully Dual Eligible Members**

**a.** 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. 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 and (ii) analyze access to and effectiveness of care provided to Members. This Ex. B, Part 8, sets 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 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 its Valid Encounter Data set of Non-Pharmacy Encounter Data as required under this Ex. B, Part 8 by no later than the Final Submission Month. Non-Pharmacy Encounter Data is related to dental, institutional, and professional encounters. All Valid Encounter Data sets shall be submitted in accordance with the AP Standard described below in 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 MCEs 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 below in 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.

**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 Dental 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. 8, 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.

**9. Encounter Data Submission Processes**

All Encounter Data must be provided to OHA through OHA's secure electronic portal in accordance with 45 CFR Part 162, OAR 410-141-3570, OAR 943-120-0100 through 943-120-0200 and as more specifically as set forth below in this Sec. 9 and Secs. 10-11 of this Ex. B, Part 8.

**a.** Contractor shall provide all Valid Encounter Data electronically in accordance with 45 CFR Part 162, OAR 410-141-3570, and OAR 943-120-0100 through 943-120-0200 using HIPAA Transactions and Codes Sets or the National Council for Prescription Drug Programs Standards and Accredited Standardized Committee X12N 837 and ASC X12N 835, formats as appropriate in accordance with OAR and OHA requirements.

**b.** In order to submit its Valid Encounter Data Contractor shall first become a trading partner and conduct data transactions in accordance with OHA Electronic Data Transaction Rules as set forth in OAR 943-120-0100 through 943-120-0200.

**c.** In accordance with 42 CFR § 438.604, 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 DCO Contract Forms Website.

**10. Additional Encounter Data Submission Requirements: Non-Pharmacy Encounter Data**

**a.** In accordance with above in this Ex. B, Part 8, Contractor shall submit all valid unduplicated Non-Pharmacy Encounter Data to OHA within 45 days after the Claims Adjudication date. If Contractor fails to provide OHA with all of its Non-Pharmacy Encounter Data within forty-five (45) days after the Claims Adjudication date or if the submissions of duplicate claims or other errors exceed five percent (5%) per month, OHA may exercise its rights under 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 above in 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 this Ex. B, Part 8 and Sec. 5 of Ex. D to this Contract.

**11. 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 Non-Pharmacy Encounter Data to OHA and certified in accordance with this Ex. B, Part 8 (e.g., format, deadlines, methods of submission, accuracy) and OAR 410-141-3570. However, if Contractor has met OHA's AP Standard, then Contractor and all other DCOs meeting the AP Standard will receive their proportional share of the total AP Withhold amounts as set forth in 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 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 (SMED) 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 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 Ex. B, Part 8, after the: (i) conclusion of any appeal undertaken under 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.

## 12. Third Party Liability, Excluding Personal Injury Liens

**a.** For the purposes of this Sec. 12, 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. 13, 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 reasonably pursued 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 up to the amount the Contractor would have paid had the Member not had other insurance.

**c.** If Contractor or Provider recovers from a Third Party Payer fees for Covered Services provided to a Member, Contractor or Provider 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 and implement written policies and procedures (P&Ps) regarding Third Party Liability recovery (TPLR). The TPLR P&Ps must include, at a minimum, all of the following:

**(1)** The requirement for Providers and Subcontractors to request and obtain TPL information from the Members and to promptly provide such information to Contractor. At a minimum, the following information must be obtained and provided to OHA:

**(a)** The name of the Third Party Payer, or in cases where the Third Party Payer has insurance to cover the liability, the name of the policy holder;

**(b)** The Member's relationship to the Third Party Payer or policy holder;

**(c)** The social security number, if available, of the Third Party Payer or policy holder;

**(d)** The name and address of the Third Party Payer or applicable insurance company;

**(e)** The policy holder's policy number for the insurance company; and

**(f)** The name and address of any Third Party who paid the claim.

**(2)** The requirement of Contractor to report any and all TPL to OHA in the timeframes identified in this Sec. 12;

**(3)** The requirement of Contractor or Provider to pursue recovery for Covered Services and the procedures to be undertaken with such efforts;

**(4)** The requirement for Contractor or Provider to document pursuit of Third Party Liability and Third Party Payer decisions;

**(5)** Policies related to record keeping of all recovery efforts undertaken, and recoveries obtained, and reporting of adjustments made to Encounter Data;

**(6)** The requirement of Contractor to adjust Encounter Data to reflect the amount received or recovered from the Third Party Payer; and

**(7)** 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 to OHA, via Administrative Notice, its TPLR P&Ps for review and approval, prior to adoption and implementation, as follows:

**(1)** No later than March 31 of each Contract Year. In the event Contractor's TPLR P&Ps have not been modified since last approved by OHA, Contractor may submit an Attestation stating that no changes have been made to the TPLR P&Ps since last approved by OHA;

**(2)** Upon any material changes, including, without limitation, adopting new TPLR P&Ps with respect to any particular service, or modifying existing TPLR P&Ps with respect to all or any services, regardless of whether OHA has provided approval of the TPLR P&Ps prior to formal adoption of the policy; and

**(3)** As may be requested by OHA from time to time.

**h.** Review and approval of Contractor's TPLR P&Ps will be based on compliance with this Contract and, to the extent OHA determines applicable, for consistency with Third Party Liability recovery requirements as set forth in 42 USC 1396a (a)(25), 42 USC 1396k, 42 CFR Part 433 Subpart D, OAR 461-195-0301 to 461-195-0350, OAR 410-141-3810, and ORS 743B.470, 659.830, 416.510 to 416.610. OHA will notify Contractor within thirty (30) days from the due date, or within thirty (30) days from the received date if after the due date, of the approval status of its TPLR P&Ps or if additional time is needed for review. In the event OHA does not approve Contractor's TPLR P&Ps, Contractor shall follow the process set forth in Sec. 5 of Ex. D to this Contract.

**(1)** Upon receipt of OHA's approval of Contractor's TPLR P&Ps, Contractor shall include in its Member Handbook the same content from its OHA approved TPLR 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. 12. The content regarding such Member obligations shall, when included in the Member Handbook, conform to the accessibility requirements described in Member Communication Requirements located on the DCO Contract Forms Website. Contractor shall follow OHA's requirements for Member Handbook content and distribution including those for any material changes.

**i.** If Contractor receives information that a Member has personal injury protection under a motor vehicle insurance policy or Other Insurance outside of OHP that has not been previously identified, 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#

**j.** OHA may require Contractor to provide the information required to be reported under Para. i. of this Sec. 12, 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.

**k.** 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.

**l.** Contractor shall require its Providers to:

**(1)** Report to Contractor any Other Insurance to which a Member may be entitled. Providers must report such information to Contractor within thirty (30) days of becoming aware Member of such coverage. Contractor must report such information to OHA within five (5) days of notice from the Provider. Contractor's reporting to OHA must be made online at the following URL: https://apps.oregon.gov/dhs/opar#; 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.

**m.** 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.

**n.** Contractor shall report all Third Party Liability recoveries to the OHP Coordination of Benefits and Subrogation Recovery Section on the quarterly report, Report L. 6 (sheet 6) of Exhibit L Financial Report Template (See Sec. 3, Ex. L).

**o.** Contractor shall adjust any Encounter Data within the timeframes specified under Secs. 10-13 above of this Ex. B, Part 8 to reflect Third Party Liability recoveries for such Encounter Data.

**p.** 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.

**q.** 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.

**13. Personal Injury Liens**

**a.** The Personal Injury Liens (PIL) Unit of the Office of Payment Accuracy and Recovery (OPAR) of DHS is authorized pursuant to OAR 461-195-0303 to administer the Personal Injury Lien program for OHA and DHS.

**b.** When health care services or items have been provided to a Member and payment for such services or items have been made by the State under Medicaid, but a Third Party nonetheless has the legal liability for such payments, the Member, pursuant to ORS 659.830(3) and 743B.470(3), is deemed to have automatically assigned to the State the right to such payment from the Third Party.

**c.** Contractor or Provider shall confirm with Members at time of service if the visit is related to an accident or injury caused by a legally liable third party, such as a motor vehicle accident, workers' compensation, or assault.

d. As related to a Personal Injury such as a motor vehicle accident, workers' compensation, or assault, 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, and such information must be made in accordance with OAR 461-195-0301 through 461-195-0350 and ORS 416.510 to 416.610.

Contractor or Provider shall report to OHA if known the Member's name and address, date of injury to the Member, Insurance or Attorney information for either the Member or liable party.

**(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.

e. 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.

f. 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.

g. 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.

h. In the event a Member or a third-party initiates litigation, Contractor shall promptly, but in no case later than ten (10) days after learning of such initiation, notify OHA via Administrative Notice.

**(1)** 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.

**(2)** 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.

**(3)** Contractor and its Subcontractor(s) shall enter into any data-sharing agreements as may be requested by the PIL Unit or OHA or both.

i. Contractor is the payer of last resort when there is other insurance or Medicare in effect. At OHA's discretion, or at the request of Contractor, OHA may retroactively Disenroll a Member to the time the Member acquired the Other Primary Insurance, pursuant to OAR 410-141-3080(3)(e)(A) or 410-141-3810. When a Member is retroactively Disenrolled under this Para. i, Sec. 13, 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.

j. As applicable, 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.

k. As applicable, 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.

l. 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.

m. 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.

n. As applicable, 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.

o. 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.

**14. Disclosure of Ownership Interests**

**a.** Contractor shall provide OHA with the disclosures required in this Sec. 14, Ex. B, Part 8 in accordance with the details set forth in Paras. b-c below of this Sec. 14, Ex. B, Part 8. The disclosures under Secs. 14-15, 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. 14, 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. 14, 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. 14, 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. 14, 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. 14, 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 DCO in which the Persons disclosed under Sub.Para. (1) above of this Para. b, Sec. 14, 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. 14, Ex. B, Part 8 must be provided to OHA by Contractor at all of the following times and by the following means:

**(1)** Upon amendment, Renewal, or extension of this Contract: To OHA via Administrative Notice.

**(2)** Subject to Sec. 16 below of this Ex. B, Part 8, within thirty-five (35) days after there is a change in any Person with an Ownership or Control Interest in Contractor: To OHA via Administrative Notice, and

**(3)** Upon request by OHA during the re-validation of enrollment process as set forth in 42 CFR §§ 455.104 and 455.414. Requests made under this Sub.Para. (3), Para. c, Sec. 14, 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.

## 15. Disclosure of Other Ownership Interests

In addition to the disclosures Contractor is required to make under Sec. 14 above of this Ex. B, Part 8, Contractor shall also make all of the disclosures required under this Sec. 15, 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. 15, Ex. B, Part 8.

**c.** Disclosures required to be made under this Sec. 15, 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.

**16. 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. Any such change in control shall also require the prior written consent of OHA. 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 and therefore is not subject to prior written notice to and approval by OHA.

**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 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. 11 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. 16, Ex. B, Part 8, Contractor shall provide to OHA, via Administrative Notice, all of the following:

**(1)** The name(s) and address(es) of all directors, officers, partners, owners, or persons or entities with beneficial Ownership Interest of 5% or more of the proposed New Entity's equity.

**(2)** A representation and warranty signed and dated by both the proposed New Entity and Contractor, in a form acceptable to OHA, that represents and warrants that the policies, procedures and processes issued by Contractor will be those policies, procedures, or

processes provided to, and if required, approved by, OHA by Contractor or by an existing Contractor within the past two years, and that those policies, procedures and processes still accurately describe those used at the time of the ownership change and will continue to be used by the New Entity once OHA has approved the ownership change request, except as modified by ongoing Contract and Administrative Rule requirements. If Contractor and the proposed New Entity cannot provide representations and warranties required under this subsection, OHA shall be provided with the new policies, procedures and processes proposed by the proposed New Entity for review consistent with the requirements of this Contract.

**(3)** The financial responsibility and solvency information for the proposed New Entity for OHA review consistent with the requirements of this Contract.

**(4)** Contractor's assignment and assumption agreement or such other form of agreement, assigning, transferring, Subcontracting or selling its rights and responsibilities under this Contract to the proposed New Entity, including responsibility for all Records and reporting, provision of services to Members, payment of Valid Claims incurred for dates of services in which Contractor has received a DCO 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.

## 17. 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.

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## 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's will have the right to pursue any and all remedies available to it under this Contract and at law or in equity. OHA's remedies are cumulative to the extent they are not inconsistent and OHA will have the right to pursue, in addition to the imposition of Sanctions, any remedy or remedies singly, collectively, successively, or in any order whatsoever.

### 2. Conditions that may Result in Sanctions

**a.** OHA will have the right to impose Sanctions if it determines, based on: (i) any audits (on- or off-site); (ii) review of Contractor Encounter Data; or (iii) its exercise of any of its other rights under this Contract, that Contractor has acted or failed to act as described in this Sec. 2, Ex. B, Part 9, or failed to comply with any of the other terms or conditions of this Contract. As specified in Ex. B, Part 4, Sec. 9, Para. a, Sub-Para. (7), a breach of the requirements of this Contract by a Subcontractor shall be deemed a breach of Contractor and Contractor shall be liable for such Subcontractor breach.

**b.** Without limiting Para. a above, of this Sec. 2, Ex. B, Part 9, OHA shall have the right, pursuant to 42 CFR § 438.700, to impose Sanctions when Contractor breaches this Contract as follows:[22]

**(1)** Fails to authorize or otherwise substantially provide Dentally 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 on Members premiums or charges 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,

[22] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

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, Dental condition or history indicates probable need for substantial future Dental 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 the such programs as required under this Contract;

**(10)** Fails to comply with Grievance and Appeal System requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of Grievances and Appeals, or record keeping and reporting requirements;

**(11)** Fails to pay for Dental Emergency Services and Dental Post-Stabilization Services or Dental 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 Non-Pharmacy Encounter Data in the time and manner required by Ex. B, Part 8;

**(15)** Distributes directly or indirectly through any Agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information;

**(16)** Violates of any of the other applicable requirements of sections 1903(m), 1932 or 1905(t) of the Social Security Act and any implementing regulations; or

**(17)** Violates any of the other applicable requirements of 42 USC § 1396b(m) or § 1396u-2 and any implementing regulations.

### 3. Range of Sanctions Available

**a.** In the event Contractor is in breach of this Contract, OHA will have the right to impose one or more Sanctions or any combination of Sanctions for the same breach. For illustrative purposes only, OHA will have the right, whether Contractor has breached the Contract once or has engaged in a pattern of severe, repeated misconduct in breach of this Contract, to impose a civil money penalty, while also requiring Contractor to develop and implement of a CAP, and obtain additional insurance.

**b.** Pursuant to 42 CFR § 438.702 et seq., OHA may impose one or more of any of the following Sanctions:[23]

**(1)** Civil money penalties,

**(2)** Appointment of temporary management,

**(3)** Granting Members the right to Disenroll without cause and notifying the affected Members of their right to Disenroll,

**(4)** Suspension of all new Enrollment, including automatic Enrollment,

**(5)** Suspension of Payments for Members Enrolled after the effective date of the Sanction until such time that CMS or OHA is satisfied that the reason for the imposition of Sanctions no longer exists and is not likely to recur,

**(6)** Denial of Payments under this Contract for new Members when, and for so long as, Payment for those Members is denied by CMS in accordance with 42 CFR § 438.730, or

**(7)** Other Sanctions as permitted under OAR 141-410-3530, which may include, without limitation:

**(a)** Assessment of a recovery amount equal to one percent (1%) of Contractor's last total monthly 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 $6,250 for each determination where OHA finds Contractor has done any of the following:

**(1)** Failed to authorize or to otherwise substantially provide Dentally 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.

[23] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

**(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 $25,000 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, Dental condition or history indicates probable need for substantial future Dental 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 $5,000 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 $25,000 as set forth in Para. b above of this Sec. 4, Ex. B, Part 9.

**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 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 | $250 per occurrence in addition to $125 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 | $125 per occurrence |
| **(3)** | Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination or Notice of | $500 per occurrence |

| | | |
|---|---|---|
| | Appeal Resolution or both to a Member within the timeframe defined in Contract and OAR | |
| **(4)** | Delegation of an Appeal to a Subcontractor or Delegated entity in violation of Contract terms | $500 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 | $125 per occurrence |
| **(6)** | Failure to submit a quarterly DSN Provider Capacity Report or annual DSN Provider Narrative Report or both in the file format and exact template specified by OHA | $125 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 | $25 per claim |
| **(8)** | Failure to timely submit a reporting deliverable by the due date specified in Contract | $125 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 | $125 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 | $125 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 | $125 per day for each day beyond the due date specified |
| **(12)** | Failure to notify OHA of a Member's Third Party Liability coverage within timeframes specified by Contract | An amount equal to the PMPM Payment Contractor received for the applicable Member for each month Contractor failed to report the TPL information to OHA |

**b.** In accordance with OAR 410-141-3530, nothing in this 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 Legal Notice of its intent to impose Sanction(s). The Legal Notice will explain the factual basis for the Sanction(s), reference to the applicable Section(s) of this Contract or Applicable Law that has been violated, identify the actions to be undertaken by Contractor to remedy the breach, and state Contractor's right to file, in writing within thirty (30) days of the date of receipt of the Legal Notice of Sanctions, a request for Administrative Review with the Director of OHA.

**b.** In cases where OHA determines that conditions could compromise a Member's health or safety, including compromising a Member's access to care, OHA may provisionally impose the Sanction before a requested Administrative Review is commenced or completed.

**c.** Contractor shall pay civil money penalties in full to OHA within thirty (30) days of the date of the Sanction notice, unless Contractor has made a timely written request for Administrative Review in accordance with Para. a above of this Ex. B, Part 9 and OAR 410-120-1580. In such event, Contractor may withhold payment of all or any disputed amount of a civil money penalty imposed pending the issuance of the Administrative Review decision. Absent a timely request for Administrative Review, if Contractor fails to make payment within thirty (30) days of receiving Legal Notice of the Sanction, OHA will setoff the full sum of the civil money penalty from Contractor's future Payment(s) or as otherwise provided under this Contract, until the civil money penalty is paid in full.

**d.** Contractor will not pass through civil money penalties imposed under this Contract to a Provider or Subcontractor, unless the Provider or Subcontractor caused the damage through its own actions or inactions. In addition, civil money penalties, whether paid or due must be paid by Contractor out of its profits or other administrative funds.

**e.** The Administrative Review process will be conducted in the manner described in OAR 410-120-1580(4)-(6). Contractor understands and agrees that Administrative Review is the sole avenue for review of Sanction decisions under this Contract.

**9. Notice to CMS of Contractor Sanction**

In accordance with 42 CFR § 438.724, OHA will provide written notice to the CMS Regional Office no later than thirty (30) days after OHA has imposed or lifted a Sanction, including civil money penalties, on Contractor.

**10. Program Integrity: Fraud, Waste, and Abuse Plans, Policies, and Procedures**

**a.** As set forth in additional detail in Secs. 11-18 below of this Ex. B, Part 9, Contractor is responsible for: (i) developing and implementing a Fraud, Waste, and Abuse (FWA) prevention and detection program and policies and procedures that ensure compliance with the requirements set forth in 42 CFR Part 455, 42 CFR Part 438, Subpart H, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510; and (ii) annually creating a plan for implementing its policies and procedures.

**b.** Pursuant to 42 CFR § 438.608, to the extent that Contractor Subcontracts to any third parties any responsibility for providing services to Members or processing and paying for claims, Contractor shall require its Subcontractors, pursuant to its Subcontracts, to comply with the terms and conditions set forth in Secs. 11-18 below of this Ex. B, Part 9. With respect to the requirements specified in Secs. 11-18 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 Fraud, Waste, and Abuse Prevention Policies and Procedures**

**a.** Contractor shall develop a FWA Prevention Handbook wherein Contractor sets forth its written policies and procedures in accordance with the requirements set forth in 42 CFR §§ 438.600-438.610, 42 CFR § 433.116, 42 CFR § 438.214, 438.808, 42 CFR §§ 455.20, 455.104 through 455.106, 42 CFR § 1002, OAR 410-141-3520, OAR 410-141-3625, and OAR 410-120-1510 that will enable Contractor to detect and prevent potential Fraud, Waste, and Abuse activities that have been engaged in by its employees, Subcontractors, Participating Providers, Members, and other third parties.

**b.** Contractor's FWA Prevention Handbook must include, at a minimum, all of the following:

**(1)** Designation and identification of a Chief Compliance Officer who reports directly to the CEO and the Board of Directors and who is responsible for: (i) developing and implementing the written policies and procedures set forth in this Para. b, Sec. 11, Ex. B, Part 9, and (ii) creating the Annual FWA Prevention Plan (as such Plan is described in Sec. 12 below of this Ex. B, Part 9);

**(2)** Establishment and identification of the members of a Regulatory Compliance Committee, which shall include Contractor's Chief Compliance Officer, senior level management employees, and members of the Board of Directors. The Regulatory Compliance Committee will be responsible for overseeing Contractor's Fraud, Waste, and Abuse prevention program and compliance with the terms and conditions of this Contract;

**(3)** Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and which includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor. Contractor must demonstrate continuous work towards increasing qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees. 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. 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)** A statement or narrative that articulates Contractor's commitment to complying with the terms and conditions set forth in this Ex. B, Part 9 and all other Applicable Laws;

**(5)** Written standards of conduct for all of Contractor's employees that evidences compliance with Contractor's commitment to Fraud, Waste, and Abuse prevention and enforcement in accordance with the terms and conditions of this Contract and all other Applicable Laws;

**(6)** A description of Contractor's disciplinary guidelines used to enforce compliance standards and how those guidelines are publicized;

**(7)** A system to provide and require annual attendance at training and education regarding Contractor's Fraud, Waste, and Abuse policies and procedures. Such training and education must include, without limitation, the right, pursuant to Section 1902(a)(68) of the Social Security Act, to be protected as a whistleblower for reporting any Fraud, Waste, or Abuse. 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 Fraud, Waste, and Abuse in 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;

**(8)** In addition to the training and education required under Sub. Para. (7) above, of this Para. b, Sec. 11, Ex. B, Part 9, a system to provide annual education and training to Contractor's employees who are responsible for credentialing Providers and Subcontracting with third parties. Such annual education and training must include material relating to, as set forth in 42 CFR §§ 438.608(b) and 438.214(d): (i) the credentialing and enrollment of Providers

and Subcontractors and (ii) the prohibition of employing, Subcontracting, or otherwise being Affiliated with (or any combination or all of the foregoing) with sanctioned individuals;

**(9)** Systems designed to maintain effective lines of communication between Contractor's Compliance Office and Contractor's employees and Subcontractors;

**(10)** Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees, Participating Providers, or Subcontractors who have violated Fraud, Waste and Abuse policies and procedures and any other Applicable Laws;

**(11)** Procedures for reporting Fraud, Waste, and Abuse to the appropriate agencies in accordance with Sec. 17 below of this Ex. B, Part 9;

**(12)** Provisions that provide detailed information about the State and federal False Claims Acts and other Applicable Laws, including, as provided for section 1902(a)(68) of the Social Security Act and the protections afforded to those persons who report Fraud, Waste, and Abuse under applicable whistleblower laws. The disclosures described in this Sub. Para (12) are required of Contractor only if it receives or makes payments of at least five million dollars ($5,000,000) annually as a result of its performance under this Contract;

**(13)** Procedures to routinely verify whether services that have been represented to have been delivered by Participating Providers and Subcontractors were received by Members, 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;

**(14)** A system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees, Participating Providers, Subcontractors, and Members, while maintaining the confidentiality of the Person(s) posing questions or making reports;

**(15)** Provisions for Contractor to self-report to OHA any Overpayment it received from OHA under this Contract or any other contract, agreement, or MOU entered into by Contractor and OHA. The foregoing reporting provision must include the obligation to report, as required under 42 CFR § 401.305 such Overpayment to OHA within sixty (60) days of its identification;

**(16)** Provisions for Contractor to conduct Program Integrity (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 an Fraud, Waste, or Abuse or an accounting or system error.

**(a)** If identification of Overpayment was the result of self-reporting to Contractor by a Provider, Subcontractor, other third-party, such foregoing reporting provision must include the obligation to report, as required under 42 CFR § 401.305, such Overpayment to Contractor within sixty (60) days of the Provider's, Subcontractor's, or other third-party's identification of the Overpayment.

**(b)** If Overpayment was identified by Contractor as a result of a PI Audit or investigation, such Overpayment must be reported to OHA promptly, but in no event more than seven (7) days after identifying such Overpayment.

**(c)** If Contractor suspects an Overpayment identified during a PI Audit or investigation is due to Fraud, Waste, or Abuse, such Overpayment must be reported in accordance with Sec. 17 below of this Ex. B, Part 9. All such reports made by the Provider, Subcontractor, or other third-party must include a written statement identifying the reason(s) for the return of the Excess Payment;

**(17)** In addition to the procedures for reporting required under Ex. B, Part 9, Contractor shall develop and maintain a procedure for accurately reporting all Overpayments on its quarterly and annual Financial Reports as required under Secs. 3-4, 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 this Ex. B, Part 9, or (ii) the result of a routine or planned PI Audit or other review;

**(18)** A process for Members to report Fraud, Waste or Abuse anonymously and to be protected from retaliation under applicable whistleblower laws;

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

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

**c.** Contractor shall provide its FWA Prevention Handbook to all employees or otherwise include its complete contents in Contractor's employee Handbook.

**d.** Contractor shall include, at a minimum, in its Member Handbook the following information relating to Fraud, Waste, and Abuse:

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

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

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

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

## 12. Annual FWA Prevention Plan

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

**a.** Contractor's Annual FWA Prevention Plan, must include, at a minimum, written plans and procedures for all of the 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 copy of its criteria or checklist developed and implemented to perform routine internal monitoring and routine evaluation of Subcontractors and Participating Providers for 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 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.

## 13. Review and Approval of FWA Prevention Handbook and Annual FWA Prevention Plan

**a.** Contractor shall provide to OHA, via Administrative Notice, its FWA Prevention Handbook and Annual FWA Prevention Plan for review and approval by no later than March 31 of each Contract Year. Contractor's Annual FWA Prevention Plan and the policies and procedures set forth in the FWA Prevention Handbook must not be implemented or distributed prior to approval by OHA. Contractor must utilize the FWA review template provided by OHA (located on the DCO Contract Forms Website) and include the completed template with its FWA Prevention Handbook and Annual FWA Prevention Plan submission. OHA will notify Contractor, via Administrative Notice to Contractor's Contract Administrator, 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 FWA Prevention Handbook and Annual FWA Prevention Plan. In the event OHA disapproves of either or both the Annual FWA Prevention Plan and the FWA Prevention Handbook for failing to meet the terms and conditions of this Contract and any other Applicable Laws, Contractor shall, in order to remedy the deficiencies, follow the process set forth in Sec. 5, Ex. D of this Contract. In addition, if OHA does not approve Contractor's FWA Annual Prevention Plan or the FWA Prevention Handbook, or both, by July 31 of each Contract Year due to Contractor's non-compliance with the terms and conditions in this Contract, Contractor shall be in breach of this Contract and OHA shall have the right to pursue all of its rights and remedies under this Contract, including, without limitation, the imposition of Sanctions, including a Corrective Action Plan or the imposition of civil money penalties, or both.

**b.** Contractor shall review and update its Annual FWA Prevention Plan and FWA Prevention Handbook annually and provide to OHA annually, via Administrative Notice, copies of such documents for OHA's review and approval as set forth in this Sec. 13, Ex. B, Part 9. In the event Contractor has not made any changes to its FWA Prevention Handbook since it was last approved by OHA, Contractor may instead submit an Attestation that no changes have been made since it was last approved, provided that such approval was made by OHA in the Contract Year immediately preceding the Contract Year in which Contractor desires to submit its Attestation. In no event, however, shall Contractor submit an Attestation in two consecutive Contract Years, even if Contractor did not make any changes in its FWA Prevention Handbook since the submission of the previous year's Attestation. Review, approval, and remediation of any deficiencies therein will be subject to the process set forth in Para. a above, of this Sec. 13, Ex. B, Part 9. After OHA's initial approval of Contractor's Annual FWA Prevention Plan and FWA Prevention Handbook under Para. a. of this Sec. 13, Ex. B, Part 9 Contractor shall also submit such Plan and Handbook for subsequent review and approval as follows:

**(1)** To OHA, via Administrative Notice, upon any significant revisions by Contractor, regardless of whether such changes are made prior or subsequent to annual approval by OHA, or prior to Contractor's final adoption of such Plan or Handbook after initial approval by OHA. The revised Annual FWA Prevention Plan or FWA Prevention Handbook, or both. OHA will notify Contractor within sixty (60) days from receipt of the compliance status of the policy. In the event the revised Annual FWA Prevention Plan or FWA Prevention Handbook fails to meet the terms and conditions of this Contract or Applicable Law, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.

**(2)** To OHA anytime upon OHA request. Contractor shall provide OHA with the requested Annual FWA Prevention Plan or FWA Prevention Handbook, or both, within thirty (30) days of OHA request in the manner requested by OHA. OHA will notify Contractor within sixty (60) days from the due date, or within sixty (60) 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 or FWA Prevention Handbook, or both, are not approved by OHA based on the failure to meet the terms and conditions of this Contract or any other Applicable Law, Contractor shall follow the process set forth in Sec. 5, Ex. D of this Contract.

## 14. OHA and Contractor Program Integrity Audits of Network Providers

**a.** If OHA conducts a PI Audits of Contractor's Participating Providers, or Subcontractors, or the Providers' or Subcontractors' Encounter Data that results in a finding of Overpayment, OHA will calculate the final Overpayment amount for the audited claims using the applicable Fee-for-Service fee schedule and recover the Overpayment from Contractor. Contractor shall have the right, at its discretion, to pursue recovery of the Overpayments made by Contractor to the applicable Providers and Subcontractors. OHA will provide Contractor's Contract Administrator with Administrative Notice of its findings and its decision relating to means of and timeframe for recovery of any finding of Overpayment.

**b.** OHA will provide Contractor's Contract Administrator and Chief Compliance Officer with Administrative Notice of its PI 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 PI Audit of Contractor's Participating Providers or Subcontractors 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 of the final audit report. Appeals will be conducted by OPI in the manner described in OAR 410-120-1396.

**c.** In accordance with OAR 410-120-1396, Contractor may be liable for up to triple the total Overpayment amount of the final PI Audit report if OHA, in the course of an audit of Contractor's Participating Providers or Subcontractors, discovers the Provider has continued the same or similar improper billing practices as established, or upheld if appealed, in a previously published final audit report by OPI or has been warned in writing by DHS, OHA, OPI, or DOJ about the same or similar improper billing practices.

**d.** If OHA conducts a PI Audit of Contractor's Providers or Subcontractor or the Providers' or Subcontractors' Encounter Data that results in an administrative or other non-financial finding, Contractor agrees to use the information included in OHA's final audit report to rectify any identified billing issues with its Providers and pursue financial recoveries for improperly billed claims.

**e.** If Contractor or its Subcontractors conduct PI Audits of Contractor's Providers or Providers' Encounter Data that results in a finding of Overpayment, Contractor is permitted to keep any sums recovered.

**f.** Recoveries that are retained by Contractor shall be reported to OHA as set forth in this Ex. B, Part 9 and Ex. L.

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

In addition to reporting all identified and recovered Overpayments made to Providers, Subcontractors, or other third parties in accordance with 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 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 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 Sec. 14 above of this Ex. B, Part 9.

**d.** Examples of Overpayment types that might be made to Providers, Subcontractors, or other third parties include, but are not limited to, the following:

**(1)** Payments for Non-Covered Services,

**(2)** Payments in excess of the allowable amount for an identified covered service,

**(3)** Errors and non-reimbursable expenditures in cost reports,

**(4)** Duplicate payments, and

**(5)** Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retroactive recovery process.

**e.** Contractor does not have the right, under this Sec. 15 of this Ex. B, Part 9, to retain any Overpayments made to any Provider or any Subcontractor that are recovered as a result of: (i) claims brought under the State or federal False Claims Acts; (ii) a judgment or settlement arising out of or related to litigation involving claims of Fraud; or (iii) through government investigations, such as amounts recovered by OPI or DOJ's MFCU or any other State or federal governmental entity, regardless of whether Contractor referred the matter to such parties.

## 16. Examples of Fraud, Waste, and Abuse

**a.** Examples of Fraud, Waste, and Abuse include, without limitation, any one, combination of, or all of the following:

**(1)** Providers, other DCOs, or Subcontractors that intentionally or recklessly report Encounters or services that did not occur, or where products were not provided.

**(2)** Providers, other DCOs, or Subcontractors that intentionally or recklessly report overstated or up coded levels of service.

**(3)** Providers, other DCOs, 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 DCOs, 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 DCOs, or Subcontractors that intentionally or recklessly make false statements about the credentials of persons rendering care to Members.

**(6)** Providers, other DCOs, 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 DCOs, Subcontractors that intentionally fail to render Dentally Appropriate Covered Services that they are obligated to provide to Members under this Contract, any Subcontract with Contractor, or Applicable Law.

**(8)** Providers, other DCOs, 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 DCOs, 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 Dental practices, and which: (i) results in unnecessary costs; (ii) results in reimbursement for services that are not Dentally 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 DCOs, or Subcontractors to skew the risk of unhealthy Member or potential Members toward or away from Contractor or any other DCO.

**(13)** Attempts by any individual, including Contractor's employees, Providers, Subcontractors, other DCOs, Contractor, or State employees or elected officials, to solicit kickbacks or bribes. For illustrative purposes, the offer of a bribe or kickback in connection with placing a Member into Carve-Out Services, or for performing any service that such persons are required to provide under the terms of such persons' employment, this Contract, or Applicable Law.

## 17. Contractor's Obligations to Report Fraud, Waste and Abuse

**a.** In addition to its reporting requirements with respect to Providers under this Ex. B, Part 9, Contractor shall immediately report to the Federal Department of Health and Human Services, Office of the Inspector General, any Providers, identified during the credentialing process, who are 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 (located on the DCO 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 Report must include all data points listed in the template, information on any Provider Overpayments that were recovered, the source of the Provider Overpayment recovery, and any Sanctions or Corrective Actions imposed by Contractor on its Subcontractors or Providers. 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 for each PI Audit identified in the Report as closed during the reporting quarter.

**(1)** The Annual FWA Audit Report is due March 31 of each Contract Year and must be provided to OHA via Administrative Notice; and

**(2)** The Quarterly FWA Audit Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.

**c.** Using the template provided by OHA (located on the DCO Contract Forms Website), Contractor shall submit to OHA, via Administrative Notice, an annual and quarterly summary report of FWA Referrals and cases investigated. The report must include, regardless of Contractor's own suspicions or lack thereof, any incident with any of the characteristics listed in Sec. 16 of this Ex. B, Part 9. The report must include all of Contractor's open and closed preliminary investigations of suspected and credible cases.

**(1)** The Annual FWA Referrals and Investigations Report is due March 31 of each Contract Year following the reporting year and must be provided to OHA via Administrative Notice.

**(2)** The Quarterly FWA Referrals and Investigations Report is due thirty (30) days following the end of each calendar quarter and must be provided to OHA via Administrative Notice.

**d.** In addition to the annual and quarterly summary of FWA Referrals and Investigations, Contractor shall report all suspected cases of Fraud, Waste, and Abuse, including suspected Fraud committed by its employees, Participating Providers, Subcontractors, Members, or any other third parties to OPI and DOJ's MFCU. Reporting must be made promptly but in no event more than seven (7) days after Contractor is initially made aware of the suspicious case. All reporting must be made as set forth below in Paras. h. and i below, of this Sec. 17, Ex. B, Part 9.

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

**f.** Contractor shall cooperate in good faith with MFCU and 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 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 C.F.R. § 455.23, in the event OHA determines that a credible allegation of Fraud has been made against Contractor, OHA will have the right to suspend, in whole or in part, Payments made to Contractor. In the event OHA determines that a credible allegation of Fraud has been

made against Contractor's Subcontractors, OHA will also have the right to direct Contractor to suspend, in whole or in part, the payment of fees to any and all such Subcontractors. Subject to 42 C.F.R. § 455.23(c) suspension of Payments or other sums may be temporary. OHA has the right to forgo suspension and continue making Payments, or refrain from directing Contractor to suspend payment of sums to its Subcontractors, if certain good cause exceptions are met as provided for under 42 C.F.R. § 455.23(e). In the event OHA determines a credible allegation of Fraud has been made against a Subcontractor, Contract must cooperate with OHA to determine, in accordance with the criteria set forth in 42 C.F.R. § 455.23, whether sums otherwise payable by Contractor to such Subcontractor, must be suspended or whether good cause exists not to suspend such payments.

**h. Where to Report a Case of Fraud or Abuse by a Provider**

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

**Medicaid Fraud Control Unit (MFCU)**
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

**OHA Office of Program Integrity (OPI)**
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

**(2)** Contractor shall include the above contact information for MFCU and OPI in its FWA Prevention Handbook and its Member Handbook.

**i. Where to Report a Case of Fraud or Abuse by a Member**

**(1)** Contractor, if made aware of suspected Fraud or Abuse by a Member (e.g., a Provider reporting Member Fraud, Waste and Abuse) must promptly report the incident to the DHS Fraud Investigation Unit (FIU). Such reporting may be made by mail, phone, or facsimile transmission using the following contact information:

**DHS Fraud Investigation Unit**
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

**(2)** Contractor shall include the above contact information for the DHS Fraud Investigation Unit in its FWA Prevention Handbook and its Member Handbook.

**18. Assessment of Compliance Activities**

**a.** Contractor shall submit an annual assessment Report of the quality and effectiveness of its Annual FWA Prevention Plan and the related policies and procedures included in its FWA Prevention

Handbook. This Annual FWA Assessment Report must include an introductory narrative of Contractor's efforts over the prior Contract Year and their effectiveness.

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

**(1)** Identify the number of preliminary investigations by Contractor and the final number of Referrals to OPI or MFCU or both;

**(2)** Identify the (i) number of Subcontractor and Participating Provider PI Audits and the (ii) number of Subcontractor and Provider reviews were conducted by Contractor, and whether each PI Audit and review were performed on-site or based on a review of documentation;

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

**(4)** Compliance and Fraud, Waste, and Abuse prevention activities that were performed during the reporting year. The work and activities reported in the annual assessment Report must align with the 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-d), Contractor shall provide such information for each program integrity activity or work conducted in the prior Contract Year:

**(a)** A review of the Provider PI Audit activities Contractor performed and whether such PI Audit activity was in accordance with Contractor's Annual FWA Prevention Plan;

**(b)** A description of the methodology used to identify high-risk Providers and services;

**(c)** Compliance reviews of Subcontractors, Participating Providers, and any other third parties, including a description of the data analytics relied upon;

**(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 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.

**(5)** A narrative and other information that advises OHA of: (i) the outcomes of all of the Fraud, Waste, and Abuse prevention activities undertaken by Contractor, and (ii) proposed or future process, policies, and procedure improvements to address deficiencies identified. Contractor must identify where work or activities identified in its FWA Prevention Plan were not implemented or were implemented differently than initially described by Contractor in its FWA Prevention Plan and explain how and why the FWA prevention activities changed.

**(6)** A copy of each final report resulting from Contractor's compliance reviews of its Subcontractors and Participating Providers completed during the prior Contract Year as well as any Corrective Action Plans resulting from such compliance reviews.

**c.** Contractor's Annual FWA Assessment Report must be provided to OHA, via Administrative Notice, by no later than March 31 of each Contract Year. Contractor's obligation to submit the Annual FWA Assessment Report survives expiration or termination of this Contract.

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

# Exhibit B – Statement of Work – Part 10 – Performance Improvement Projects 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 Performance Improvement Projects, which must comply with the criteria set forth in 42 CFR §§ 438.66 and 438.330, this Ex. B, Part 10, and other Applicable Law.

## 2. Performance Improvement Projects

**a.** In accordance with 42 CFR §438.330(d), Contractor shall create and implement an ongoing program of Performance Improvement Projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to 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 commit to improving care in focus areas identified by OHA. Contractor shall select one (1) or more projects from the four (4) focus areas listed below to serve as Contractor's Performance Improvement Project(s) in accordance with 42 CFR §438.330(d) and §438.340(a)(3)(ii). CMS, in consultation with OHA and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by OHA in this Contract. OHA, in consultation with other stakeholders may specify performance measures and topics for PIP. PIPs may consist of any one of four main focus areas:

**(1)** Prevention (clinical);

**(2)** Addressing populations' health issues (such as diabetes, pregnant women, tribal with specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs (clinical));

**(3)** Access and utilization (non-clinical); and

**(4)** Community (clinical or non-clinical).

**c.** Each PIP must be approved by OHA; OHA reserves the right to reject or require modification of Contractor's PIP.

**d.** Contractor shall report the status and results of each project to OHA in a format provided by OHA. Reports are due July 31 of each Contract Year and as requested by OHA.

**e.** In compliance with 42 CFR § 438.350 and § 438.358, and 42 CFR §457.1250 Contractor shall submit to and cooperate fully with EQRO validation of Contractor's PIPs.

**3. Additional Health System Transformation Obligations**

**a.** Contractor shall, in accordance with OAR 410-141-3525, convene a Quality Improvement Committee to oversee its Quality Assessment and Performance Improvement (QAPI) efforts. Contractor's Quality Improvement Committee shall oversee and be responsible for Contractor's annual Monitoring of QAPI activities.

**b.** Contractor shall comply with the mission, objectives, and guidelines of the QAPI Workgroup. This includes, but is not limited to, specific prevention projects, both at the Contractor and State levels, collection and measurement of data, and regular intervals of data submissions

**4. External Quality Review**

**a.** In conformance with 42 CFR § 438.350 and § 438.358, and 42 CFR § 457.1250, Contractor shall permit OHA and its designees to have access to, or provide OHA with, Contractor's Records and facilities, and information requested by OHA and its designees, for the purpose of an annual External Quality Review of Contractor's compliance with all Applicable Laws and this Contract as well as the quality outcomes and timeliness of, and access to, services provided under this Contract.

**b.** An External Quality Review Organization will perform the annual EQR as determined by OHA. In the event OHA designates an EQRO to perform the EQR, OHA will ensure the EQRO meets the criteria set forth in 42 CFR § 438.354. In addition, OHA will, in accordance with 42 CFR § 438.310 and § 438.350, also do, in connection with the EQR, all of the following:

**(1)** Implement an EQR protocol that complies with CMS protocols required by 42 CFR § 438.352 and provide such protocols to Contractor, prior to the EQR;

**(2)** Provide information previously received from Contractor to the EQRO in an effort to reduce Contractor's duplicative submissions as directed by 42 CFR § 438.360;

**(3)** Require the EQRO to produce a report and information required under 42 CFR § 438.364 and to provide such information to Contractor promptly after completion; and

**(4)** Ensure that EQR results are made available, as required in 42 CFR § 438.364, in an annual detailed technical Report that summarizes findings on access and quality of care.

**c.** Consistent with 42 CFR § 438.350, § 438.358, and § 457.1250 the EQRO will:

**(1)** Perform an EQR in a manner consistent with protocols established by CMS, which shall include, at a minimum, the elements in 42 CFR § 438.358(b).

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

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

**(4)** Provide technical guidance, or direct the EQRO to provide technical guidance as directed by OHA, to Contractor to assist Contractor in conducting activities related to the mandatory and additional activities described in 42 CFR § 438.358 that provide information for the EQR and the resulting EQR technical Report.

**d.** All annual EQR technical reports will be posted on OHA website by April 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.

***[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 DCO Payment for each Member enrolled under the Contract according to OHA records. The monthly DCO Payment Rate authorized for each Member is that amount indicated in Exhibit C-Attachment 1 (DCO Payment Rates) for each Member's Rate Group. OHA will prorate the DCO 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.** All DCO 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 DCO Payment Rates may be changed only by amendment to this Contract pursuant to Sec. 21, Ex. D.

**b.** In the event DCO 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 DCO Payment Rates as a result of adjustments to the Service Area or to the Enrollment limit may be required pursuant to Sec. 11, Ex. B, Part 4 of this Contract.

**d.** The DCO Payments authorized to be paid under this Contract are based on the funded condition-treatment pairs on the Prioritized List of Health Services in effect on the date this Contract is executed, subject to the terms of this Contract. Changes in the Prioritized List may result in changes in DCO Payment Rates, as follows:

**(1)** Pursuant to ORS 414.690, the Prioritized List of Health Services of Condition/Treatment Pairs developed by the Health Evidence Review Commission may be expanded, limited or otherwise changed. Pursuant to ORS 414.690 and 414.735, the funding line for the services on the Prioritized List of Health Services may be changed by the Legislature.

**(2)** In the event that insufficient resources are available during the Term of this Contract, ORS 414.735 provides that reimbursement shall be adjusted by eliminating services in the order of priority recommended by the Health Evidence Review Commission, starting with the least important and progressing toward the most important.

**(3)** Before instituting reductions in Covered Services pursuant to ORS 414.735, OHA will obtain the approval of the Legislative Assembly or the Emergency Board if the Legislative Assembly is not in session.

**(4)** If legislative scheduling permits, OHA will provide Contractor Administrative Notice to Contractor's Contract Administrator at least two (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 DCO 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 Para. (5) or Para. (5), Sub.Para. (a) above for services subject to the adjustment is less than 1% of the total OHP rates, no adjustment to the DCO Payment Rates will be made.

**(c)** If the net result under Para. (5) or Para. (5), Sub.Para. (a) above is 1% or greater of the total OHP rates, the DCO 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.** This Sec. 3 applies to any change to the DCO 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 DCO 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 DCO 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 DCO Payments

**a.** The date on which OHA will process DCO 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, DCO 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, DCO 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, DCO 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 DCO 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 DCO 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 DCO 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 DCO 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 DCO 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 DCO 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.

**6. Rate Methodology**

OHA has developed actuarially set Adjusted Per Capita Costs (Capitation Rates) to reimburse plans for providing the Covered Services. A full description of the methodology used to calculate per capita costs may be found in the OHA document ***"Oregon CY22 Rate Certification – DCO Rates"***. The Actuarial Report is available at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/OHP-Rates.aspx. The Actuarial Report is not part of this Contract, and except where specifically referred to herein, may not be used in the interpretation or construction of this Contract.

**7. Medical Loss Ratio**

**a.** In accordance with 42 CFR § 438.8 Contractor shall submit, in accordance with this Section, an annual certified Medical Loss Ratio Calculation Report which calculates Contractor's MLR Report which validates compliance with the requirements set forth in this Section. .

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

**(1)** "MLR Calculation Report" means Contractor's report of financial information required for calculating MLR,

**(2)** "Reporting Period" means calendar year.

**c.** Contractor shall file its MLR Calculation Report electronically utilizing the Medical Loss Ratio Calculation template (Excel Workbook). In creating its MLR Calculation Report, Contractor shall comply with 42 CFR § 438.8 and also follow the MLR Calculation Report Instructions supplied by OHA. All information reported on the MLR Calculation Report must be for revenues and expenses under this Contract or under a Predecessor DCO Contract between OHA and Contractor. The MLR Calculation Report must be certified by an officer of Contractor, under penalty of false claims act liability, in the manner required by the MLR Calculation Report Instructions.

**d.** Contractor shall file its MLR Calculation Report for each Reporting Period with OHA's secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA. The obligation to file the MLR Calculation Report survives termination or expiration of this Contract and is due each year by August 31 of the year following the Reporting Period.

**e.** OHA will review Contractor's filed MLR Calculation Report as follows:

**(1)** If OHA determines that Contractor's MLR Calculation Report is complete and accurate, OHA will issue a final determination that Contractor has fulfilled its obligation under this Section and 42 CFR § 438.8.

**(2)** If OHA determines that Contractor's MLR Calculation Report is incomplete or inaccurate, OHA will provide or request proposed revisions to the MLR Calculation Report. Contractor shall supply any information requested by OHA in connection with the MLR Calculation Report within ten (10) Business Days of the request. The revised MLR Calculation Report will become final for purposes of the MLR calculations ten (10) Business Days after the date of the revisions, unless OHA's Contract Administrator

receives from Contractor, via Administrative Notice, 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 MLR Calculation Reports that it has appealed. The decision on Administrative Review will result in a final MLR Calculation Report if an appeal was timely filed.

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

## Exhibit C – Consideration - Attachment 1 – DCO Payment Rates

***(DCO 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 section be construed as a waiver by the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any Claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the United States or otherwise. **CONTRACTOR, BY EXECUTION OF THIS CONTRACT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.**

### 2. Compliance with Applicable Law

**a.** Contractor shall comply and cause all Subcontractors to comply with all State and local laws, regulations, executive orders and ordinances applicable to this Contract or to the performance of Work as they may be adopted, amended or repealed from time to time, including but not limited to the following: (i) ORS 659A.142; (ii) OHA rules pertaining to the provision of integrated and coordinated care and services, OAR Chapter 410, Division 141; (iii) all other OHA Rules in OAR Chapter 410; (iv) rules in OAR Chapter 309, Divisions 012, 014, 015, 018, 019, 022, 032 and 040, pertaining to the provisions of Behavioral Health services; (v) rules in OAR Chapter 415 pertaining to the provision of Substance Use Disorders services; (vi) state law establishing requirements for Declaration for Mental Health Treatment in ORS 127.700 through 127.737; and (vii) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations. These laws, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. OHA's performance under this Contract is conditioned upon Contractor's compliance with the provisions of ORS 279B.220, ORS 279B.225, 279B.230, 279B.235 and 279B.270, which are incorporated by reference herein. Contractor shall, to the maximum extent economically feasible in the performance of this Contract, use recycled paper (as defined in ORS 279A.010(1)(gg)), recycled PETE products (as defined in ORS 279A.010(1)(hh)), and other recycled products (as "recycled product" is defined in ORS 279A.010(1)(ii)).

**b.** In compliance with the Americans with Disabilities Act, any written material that is generated and provided by Contractor under this Contract to Clients or Members, including Medicaid-Eligible Individuals, shall, at the request of such Clients or Members, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. OHA shall not reimburse Contractor for costs incurred in complying with this provision. Contractor shall cause all Subcontractors under this Contract to comply with the requirements of this provision.

**c.** Contractor shall comply with the federal laws as set forth or incorporated, or both, in this Contract and all other federal laws applicable to Contractor's performance under this Contract as they may be adopted, amended or repealed from time to time.

**3. Independent Contractor**

**a.** Contractor is not an officer, employee, or Agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

**b.** If Contractor is currently performing work for the State of Oregon or the federal government, Contractor by signature to this Contract, represents and warrants that Contractor's Work to be performed under this Contract creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Contractor currently performs work would prohibit Contractor's Work under this Contract. If compensation under this Contract is to be charged against federal funds, Contractor certifies that it is not currently employed by the federal government.

**c.** Contractor is responsible for all federal and State taxes applicable to compensation paid to Contractor under this Contract and, unless Contractor is subject to backup withholding, OHA will not withhold from such compensation any amounts to cover Contractor's federal or State tax obligations. Contractor is not eligible for any social security, unemployment insurance or workers' compensation benefits from compensation paid to Contractor under this Contract, except as a self-employed individual.

**d.** Contractor shall perform all Work as an Independent Contractor. OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, OHA may not and will not Control the means or manner of Contractor's performance. Contractor is responsible for determining the appropriate means and manner of performing the Work.

**4. Representations and Warranties**

**a.** Contractor 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 Section are in addition to, and not in lieu of, any other warranties provided.

**5. Correction of Deficient Documents**

For all reports, policies and procedures, handbooks, materials, and any other documents required to be provided to OHA or other state or federal agency under this Contract for review and approval (for this 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; or

**(8)** Contractor fails to enter into an amendment described in Sec. 20, Para. b below of this Ex. D, as necessary for the amendment to go into effect on its proposed effective date.

**(9)** Any notice of default by Contractor shall identify, with specificity, the term or terms of this Contract allegedly breached.

**b. OHA's Remedies for Contractor's Default.** In the event Contractor is in default under Sec. 9, Para. a, above of this Ex. D, OHA may, at its option, pursue any or all of the remedies available to it under this Contract and at law or in equity, including, but not limited to:

**(1)** Termination of this Contract under Sec. 9, Para. e, Sub. Para. (2) below of this Ex. D. below;

**(2)** Withholding all monies due for Work and Work Products that Contractor has failed to deliver within any scheduled completion dates or has performed inadequately or defectively;

**(3)** Sanctions, including civil monetary penalties if applicable, as permitted under Ex. B, Part 9 of this Contract;

**(4)** Initiation of an action or proceeding for damages, specific performance, declaratory or injunctive relief; and

**(5)** Recoupment or Withholding of Overpayments under Sec. 7 above of this Ex. D or Offset or both.

These remedies are cumulative to the extent the remedies are not inconsistent, and OHA may pursue any remedy or remedies singly, collectively, successively or in any order whatsoever.

**c. Default by OHA.** OHA will be in default under this Contract if:

**(1)** OHA fails to pay Contractor any amount pursuant to the terms of this Contract, net of any Withholding or Recoupment for Overpayment or other Offset, and OHA fails to cure such failure within fifteen (15) days after receipt of Contractor's Legal Notice of such failure to pay or such longer period as Contractor may specify in such Legal Notice; or

**(2)** OHA commits any breach of any covenant, warranty, or obligation under this Contract, and such breach or default is not cured within thirty (30) days after Contractor's Legal Notice or such longer period as Contractor may specify in such Legal Notice.

Any notice of default by Contractor shall identify, with specificity, the term or terms of this Contract allegedly breached.

**d. Contractor's Remedies for OHA's Default.** In the event OHA is in default under Sec. 9, Para. c. above of this Ex. D, 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 ninety (90) 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. 15, "Force Majeure," upon receipt of written Legal Notice of termination to Contractor if OHA determines that continuation of the Contract poses a threat to the health, safety, or welfare of any Member, including any Medicaid eligible individual, under Contractor's care.

**(2)** OHA's Right to Terminate for Cause. In addition to any other rights and remedies OHA may have under this Contract, and subject to Sec. 9, Para. e, Sub. Para. (3) below of this Ex. D, OHA will have the right, at its sole discretion and without liability to Contractor, to issue Legal Notice to Contractor that OHA is terminating this Contract upon the occurrence of any of the following events:

**(a)** Contractor is in default under Sec. 9, Para. a, Sub. Para. (1) above of this Ex. D because Contractor has instituted or has had instituted against it insolvency, receivership or bankruptcy proceedings, makes an assignment for the benefit of creditors, or ceases doing business on a regular basis; or

**(b)** Contractor is in default under Sec. 9, Para. a, Sub. Para. (2) above of this Ex. D because Contractor no longer holds a license or certificate that is required for it to perform Work under the Contract and Contractor has not obtained such license or certificate; or

**(c)** Contractor is in default under Sec. 9, Para. a, Sub. Para. (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.

**(d)** Contractor has failed to carry out the substantive terms of its Contract or meet the applicable requirements of 1932, 1903(m) or 1905(t) of the Social Security Act.

**(3)** Before Terminating this Contract under this Sec. 9, Para. e, Sub. Para (1) or Sub. Para. (2) above of this 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.

**(4)** Contractor's Right to Terminate for Cause. Contractor may terminate this Contract for cause if OHA is in default under Sec. 9, Para. c above of this Ex. D and fails to cure such default within the time specified therein.

**(5)** Contractor's Right to Terminate at its Discretion.

**(a)** OHA may offer to Renew the Contract for an additional one (1) year term. If OHA offers to Renew the Contract, no later than one hundred and four (104) days prior to the end of a Contract Year, 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 ninety (90) days prior to the effective date of any Renewal Contract, for termination effective as of the Renewal effective date. A refusal by Contractor to enter into a Renewal Contract terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D.

**(b)** If the Oregon Legislature adopts budgetary changes that require OHA to alter the rates under this Contract, OHA will prepare and offer Contractor a required amendment to the rates (the **"Required Rate Amendment"**). No later than one hundred and four (104) 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 ninety (90) days prior to the effective date of the Required Rate Amendment, for termination effective as of the effective date of the Required Rate Amendment. A refusal by Contractor to enter into the Required Rate Amendment terminates this Contract, regardless of whether Contractor provided the Legal Notice described in this Sec. 9, Para. e, Sub. Para. (5) of this Ex. D and has the same effect as the failure to enter into a Renewal Contract.

**(6)** Notwithstanding Contractor's Legal Notice of termination or failure to enter into a Renewal Contract or the Required Rate Amendment under Sec. 9, Para. e, Sub. Para. (5) above of this Ex. D, OHA will have the right to require the Contract to remain in full force and effect and be amended as proposed by OHA until ninety (90) days after Contractor has, in accordance with the criteria prescribed by OHA, provided a Transition Plan in accordance with Sec. 10, Para. a below of this Ex. D.

**(7)** OHA may waive compliance with the deadlines in Sub. Paras. (5) and (6) of this Sec. 9, Para. e, of this Ex. D if OHA finds that the waiver of the deadlines is consistent with the effective and efficient administration of the Medicaid program and the protection of Members. If Contractor if offered but 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 2022 Required Rate Amendment) to OHA ninety (90) days prior to the date of any Renewal Contract, OHA will have the right to extend this Contract for the period of time OHA considers necessary, in its sole discretion, to accomplish the termination planning described in this Sec. 9, Para. e, Sub. Para (6) of this Ex. D.

**(8)** After receipt of Contractor's Notification of intent not to Renew (or not to enter into the Required Rate Amendment), or upon an extension of this Contract as described in Sub. Paras. (6) and (7) of this Sec. 9, Para. e above of this Ex. D, OHA will issue written Notice to Contractor specifying the effective date of termination, Contractor's operational and reporting requirements, and timelines for submission of deliverables.

**(9)** Mutual Termination. This Contract may be terminated immediately upon mutual written consent of the parties or at such other time as the parties may agree in the written consent.

**(10)** Automatic Termination. This Contract will automatically be subject to termination under the condition described in Sec. 9, Para. a, Sub. Para. (7) and Para. e, Sub. Para. (6) above of this Ex. D (refusal to enter into an amended contract).

**(11)** The party initiating the termination shall render written Legal Notice of termination to the other party and must specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination is proposed to become effective.

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

**a.** After providing or receiving Legal Notice of termination, or, in the case of expiration under Sec. 1.1 of the General Provisions to this Contract, at least ninety (90) 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 DCO 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)** Facilitating and scheduling of Dentally 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;

**(b)** Identifying chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy;

**(c)** 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 Oral Health 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)** Program exceptions approved;

**(c)** Current hospitalizations;

**(d)** Information on Members in Treatment Plans/plans of care who will require Continuity of Care consideration;

**(e)** Any other information or records deemed necessary by OHA to facilitate the transition of care.

**(f)** Arrange for the retention, preservation, and availability of all Records under this Contract, including, but not limited to those Records related to Member Grievance and Appeal records, litigation, base data, Medical Loss Ratio data, financial reports, claims settlement information, as required by Contract, State and federal law.

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

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

**(1)** OHA need not furnish a Legal Notice or any other type of notice of termination for a termination by expiration;

**(2)** If OHA offers Contractor a successor contract to be effective immediately upon expiration of this Contract, then OHA will provide Contractor with Legal Notice of the proposed terms and conditions of the Contract, as will be submitted by OHA to CMS for approval, and within fourteen (14) days of receipt of the CMS approved successor contract, Contractor shall provide OHA with Legal Notice if Contractor does not intend to enter the successor contract. Such Legal Notice will not relieve Contractor of any undertakings Contractor has provided to OHA in the procurement for the successor contract;

**(3)** If OHA and Contractor enter into a successor contract that is effective immediately after expiration of this Contract, then OHA may waive those duties of Contractor relating to termination of this Contract that OHA deems unnecessary in view of the successor contract; and

**(4)** Contractor shall perform the actions described in Sec. 10 of this Ex. D relating to Transition Plan and close-out activities, but only to the extent required by OHA in writing. Contractor shall provide a Transition Plan, to the extent required by OHA in writing, ninety (90) 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 DCO Payment has been made;

**(2)** Plan and carry out an orderly and reasonable transfer of Member care in progress;

**(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 DCO 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 DCO Payments for that month shall be apportioned on a daily basis. Contractor shall be entitled to DCO 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 DCO 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 DCO 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. Access to Records and Facilities; Records Retention; Information Sharing

**a.** Contractor shall maintain, and require its Subcontractors and Participating Providers to maintain, all financial records relating to this Contract in accordance with best practices or National Association of Insurance Commissioners accounting standards. In addition, Contractor shall

maintain any other Records in such a manner as to clearly document Contractor's performance. Contractor acknowledges and agrees that OHA, CMS, the Oregon Secretary of State, DHHS, the Office of the Inspector General, the Comptroller General of the United States, the Oregon Department of Justice (DOJ) Medicaid Fraud Control Unit and their duly authorized representatives shall have access to all Contractor, Participating Provider, and Subcontractor Records for the purpose of performing examinations and audits and make excerpts and transcripts, evaluating compliance with this Contract, and to evaluate the quality, appropriateness and timeliness of services. Contractor further acknowledges and agrees that the foregoing entities may, at any time, inspect the premises, physical facilities, computer systems, and any other equipment and facilities where Medicaid-related activities or Work is conducted or equipment is used (or both conducted and used).

**(1)** The right to audit under this section exists for 10 years from, as applicable, the Expiration Date or the date of termination, or from the date of completion of any audit, whichever is later.

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

**b.** Contractor shall retain and keep accessible all Records for the longer of ten years or:

**(1)** The retention period specified in this Contract for certain kinds of Records;

**(2)** The period as may be required by Applicable Law, including the records retention schedules set forth in OAR Chapters 410 and 166; or

**(3)** Until the conclusion of any audit, controversy or litigation arising out of or related to this Contract.

**c.** In accordance with OAR 410-141-5080, OHA has the right to provide the Oregon Department of Consumer and Business Services with information reported to OHA by Contractor provided that OHA and DCBS have entered into information sharing agreements that govern the disclosure of such information.

## 15. Force Majeure

**a.** Neither OHA nor Contractor shall be held responsible for delay or default caused by riots, acts of God, power outage, fire, civil unrest, labor unrest, 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. 15 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 Dental Emergency Services;

**(2)** Care is needed for Dental Urgent Care Services; or

**(3)** Care is needed where there is a potential for a serious adverse Dental consequence if treatment or diagnosis is delayed more than thirty (30) days.

**c.** If any of the circumstances listed in Para. a, Sec. 15 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.

**16. Foreign Contractor**

If Contractor is not domiciled in or registered to do business in the State of Oregon, Contractor shall promptly provide to the Department of Revenue and the Secretary of State Corporation Division all information required by those agencies relative to this Contract.

**17. Assignment of Contract, Successors in Interest**

**a.** Contractor shall not assign or transfer its interest in this Contract, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other manner, without prior written consent of OHA. Any such assignment or transfer, if approved, is subject to such conditions and provisions as OHA may deem necessary, including but not limited to Ex. B, Part 8, Sec. 16. No approval by OHA of any assignment or transfer of interest shall be deemed to create any obligation of OHA in addition to those set forth in the Contract.

**b.** The provisions of this Contract shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

**18. Subcontracts**

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. Sections 1, 2, 3, 4, 14, 15, 17, 18, 23, and 29-31 of this Ex. D. OHA's consent to any Subcontract shall not relieve Contractor of any of its duties or obligations under this Contract.

**19. No Third Party Beneficiaries**

OHA and Contractor are the only parties to this Contract and are the only parties entitled to enforce its terms. The parties agree that Contractor's performance under this Contract is solely for the benefit of OHA to accomplish its statutory mission. Nothing in this Contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons any greater than the rights and benefits enjoyed by the general public unless such third persons are individually identified by name herein and expressly described as intended beneficiaries of the terms of this Contract.

**20. Amendments**

**a.** OHA may amend this Contract to the extent provided herein 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 DCO 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 DCO 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 DCO 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 DCO 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.

**21. Waiver**

No waiver or other consent under this Contract shall bind either party unless it is in writing and signed by the party to be bound. Such waiver or consent shall be effective only in the specific instance and for the specific purpose given. The failure of either party to enforce any provision of this Contract shall not constitute a waiver by that party of that or any other provision.

**22. Severability**

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

**23. Survival**

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. 23. 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 D: Secs. 1, 4 through 28, and 30.

**d.** 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.

**e.** Exhibit N shall survive termination for the period of time that Contractor retains any Access (as such term is defined in Sec. 2.1 of Ex. N) to OHA or State Data, Network and Information Systems, and Information Assets.

**f.** Special Terms and Conditions:

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

**(1)** Claims Data

**(a)** The submission of all Encounter Data for services rendered to Contractor's Members during the contract period;

**(b)** Certification that Contractor attests that the submitted encounter claims are complete, truthful and accurate to the best knowledge and belief of Contractor's authorized representative, subject to False Claims Act liability;

**(c)** Adjustments to encounter claims in the event Contractor receives payment from a Member's Third Party Liability or Third Party recovery; and

**(d)** Adjustments to encounter claims in the event Contractor recovers any Provider Overpayment from a Provider.

**(2)** Financial Reporting

**(a)** Quarterly financial statements as defined in 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 MLR; 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;

**(b)** Not initiating voluntary bankruptcy, liquidation, or dissolution;

**(c)** Maintenance of all licenses, certifications, and registrations necessary to do the business of a DCO 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 and right of setoffs;

**(b)** Recoupment of capitation paid for Members deemed ineligible or who were enrolled into an incorrect benefit category; and

**(c)** 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.

**24. 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. 24.

**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. 24, 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. 24, 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. 24, 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: DCO.DeliverableReports@dhsoha.state.or.us

**(d)** In the event this Contract is silent with respect to a due date for any deliverable, Contractor shall request a due date from OHA, via Administrative Notice, sent to the email address in Sub. Para. (1)(c) of this Para. b, Sec. 24, 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. 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. 24, Para. b.

**c. If Contract is Silent**. In the event a particular provision in this Contract is silent with respect to the means or method of communication, the communication shall be made to OHA's Contract Administrator by Administrative Notice.

## 25. Construction

This Contract is the product of extensive negotiations between OHA and Contractor. The provisions of this Contract are to be interpreted and their legal effects determined as a whole. The rule of construction that ambiguities in a written agreement are to be construed against the party preparing or drafting the agreement shall not be applicable to the interpretation of this Contract.

**26. Headings 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.

**27. Merger Clause**

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

**28. Counterparts**

This Contract and any subsequent Amendments may be executed in several counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Contract and any Amendments so executed shall constitute an original.

**29. Equal Access**

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

**30. Media Disclosure**

Contractor shall not provide information to the media regarding a recipient of services under this Contract without first consulting with and receiving approval from 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.

**31. Mandatory Reporting of Abuse**

**a.** Contractor shall immediately report any evidence of Child Abuse, neglect or threat of harm to DHS Child Protective Services or law enforcement officials in full accordance with the mandatory Child Abuse Reporting law (ORS 419B.005 to 419B.045). If law enforcement is notified, Contractor shall notify the referring caseworker within 24 hours. Contractor shall immediately contact the local DHS Child Protective Services office if questions arise whether an incident meets the definition of Child Abuse or neglect.

**b.** Contractor shall comply, and shall require its Participating Providers to comply, with all protective services, investigation and reporting requirements described in any of the following laws:

**(1)** OAR Chapter 407, Divisions 45 to 47 (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 county developmental disability program;

**(2)** Adults with mental illness to the local county mental health program;

**(3)** Patients of the Oregon State Hospital or residents of Substance Use Disorder treatment facilities to DHS OTIS;

**(4)** Elder Abuse to the local DHS Aging & People with Disabilities office or Area Agency for Aging;

**(5)** Nursing facility residents to the DHS 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 DHS.

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

## Exhibit E – Required Federal Terms and Conditions

Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, Contractor shall comply and, as indicated, cause all Subcontractors to comply with the following federal requirements to the extent that they are applicable to this Contract, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Contract, all references to federal and State laws are references to federal and State laws as they may be amended from time to time.

### 1. Miscellaneous Federal Provisions

Contractor shall comply and require all Subcontractors to comply with all federal laws, regulations and executive orders applicable to this Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and require all Subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to this Contract: (a) Title VI and VII of the Civil Rights Act of 1964, as amended; (b) 45 CFR Part 84 which implements, Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended; (c) the Americans with Disabilities Act of 1990, as amended; (d) Section 1557 of the Patient Protection and Affordable Care Act (PPACA); (e) Executive Order 11246, as amended; (f) the Health Insurance Portability and Accountability Act of 1996, as amended; (g) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended; (h) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; (i) the Mental Health Parity and Addiction Equity Act of 2008, as amended; (j) CMS regulations (including 42 CFR Part 438, subpart K) and guidance regarding mental health parity, including 42 CFR 438.900 et. seq.; (k) all regulations and administrative rules established pursuant to the foregoing laws; (l) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations; and (m) all federal laws requiring reporting of Member abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to this Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC. 14402.

### 2. Equal Employment Opportunity

If this Contract, including Amendments, is for more than $10,000, then Contractor shall comply and require all Subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

### 3. Clean Air, Clean Water, EPA Regulations

If this Contract, including Amendments, exceeds $100,000 then Contractor shall comply and require all Subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC. 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported in writing to: (a) OHA via Administrative Notice; (b) United States Department of Health and Human Services; and (c) the appropriate Regional Office of the federal Environmental Protection Agency. Contractor shall include and require all Subcontractors to include in all contracts with Subcontractors receiving more than $100,000, language requiring the Subcontractor to comply with the federal laws identified in this section.

**4. Energy Efficiency**

Contractor shall comply and require all Subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163).

**5. Truth in Lobbying**

By signing this Contract, Contractor certifies, to the best of Contractor's knowledge and belief that:

**a.** No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any Person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement.

**b.** If any funds other than federal appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

**c.** Contractor shall require that the language of the certification made under this Sec. 5 of this 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 Section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or

future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

**h.** No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant Dental evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

**6. HIPAA Compliance**

The parties acknowledge and agree that each of OHA and Contractor is a "covered entity" for purposes of privacy and security provisions of the Health Insurance Portability and Accountability Act and its implementing federal regulations (collectively referred to as HIPAA). OHA and Contractor shall comply with HIPAA to the extent that any Work or obligations of OHA arising under this Contract are covered by HIPAA. Contractor shall develop and implement such policies and procedures for maintaining the privacy and security of Records and authorizing the use and disclosure of Records required to comply with this Contract and with HIPAA. Contractor shall comply and cause all Subcontractors to comply with HIPAA and the following:

**a.** Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is protected from unauthorized use or disclosure consistent with the requirements of HIPAA. Individually Identifiable Health Information relating to specific individuals may be exchanged between Contractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under this Contract. However, Contractor shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division 014, or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://sharedsystems.dhsoha.state.or.us/forms/, Form number ME2090 Notice of Privacy Practices, or may be obtained from OHA.

**b.** HIPAA Information Security. Contractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rules in 45 CFR Part 164 to ensure that Member Information shall be used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with Applicable Laws and the terms and conditions of this Contract. Security incidents involving Member Information must be immediately reported, via Administrative Notice, to the Privacy Compliance Officer in OHA's Information Security and Privacy Office (ISPO) at DHS.PrivacyHelp@dhsoha.state.or.us, 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 Dentally Appropriate Covered Services provided to a Member. Contractor shall comply with all requirements of Sections 4204 (a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 that concern Practitioner Incentive Plans.

**16. Risk HMO**

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

**17. Conflict of Interest Safeguards**

**a.** Contractor shall not offer, promise, or engage in discussions regarding future employment or business opportunity with any DHS or OHA employee (or their relative or Member of their household), and no DHS or OHA employee shall solicit, accept or engage in discussions regarding future employment or business opportunity, if such DHS or OHA employee participated personally and substantially in the procurement or administration of this Contract as a DHS or OHA employee.

**b.** Contractor shall not offer, give, or promise to offer or give to any DHS or OHA employee (or any relative or Member of their household), and such employees shall not accept, demand, solicit, or receive any gift or gifts with an aggregate value in excess of $50 during a calendar year or any gift of payment of expenses for entertainment. "Gift" for this purpose has the meaning defined in ORS 244.020 and OAR 199-005-0001 to 199-005-0035.

**c.** Prior to the award of any replacement contract, Contractor shall not solicit or obtain, from any DHS or OHA employee, and no DHS or OHA employee may disclose, any proprietary or source selection information regarding such procurement, except as expressly authorized by the Director of OHA or DHS.

**d.** Contractor shall not retain a former DHS or OHA employee to make any communication with or appearance before OHA on behalf of Contractor in connection with this Contract if that Person participated personally and substantially in the procurement or administration of this Contract as a DHS or OHA employee.

**e.** If a former DHS or OHA employee authorized or had a significant role in this Contract, Contractor shall not hire such a Person in a position having a direct, beneficial, financial interest in this Contract during the two-year period following that Person's termination from DHS or OHA.

**f.** Contractor shall develop and maintain (and update as may be needed from time to time) a Conflict of Interest Safeguards Handbook wherein Contractor shall set forth appropriate, written policies and procedures to avoid actual or potential conflict of interest involving Members, DHS, or OHA employees, and Subcontractors. These policies and procedures shall include, at a minimum, safeguards:

**(1)** against Contractor's disclosure of Applications, bids, proposal information, or source selection information; and

**(2)** requiring Contractor to:

**(a)** promptly report, but in no event seven (7) Business Days after impermissible contact, any contact with a Contractor, bidder, or offeror in writing, via Administrative Notice, to OHA's Contract Administrator; and

**(b)** reject the any offer or proposed offer of employment; or disqualify itself from further personal and substantial participation in the procurement if Contractor contacts or is contacted by a Person who is a contractor, bidder, or offeror in a procurement involving federal funds regarding possible employment for Contractor.

**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 DCO Contract or other similar contract between Contractor and OHA for a previous Term.

**(2)** Contractor shall apply the definitions in the State Public Ethics Law, ORS 244.020, for "actual conflict of interest," "potential conflict of interest," "relative," and "Member of household."

**(3)** "Contractor" for purposes of this section includes all Contractor's Affiliates, assignees, subsidiaries, parent companies, successors and transferees, and persons under common Control with Contractor; any officers, directors, partners, Agents and employees of such Person; and all others acting or claiming to act on their behalf or in concert with them.

**(4)** "Participates" means actions of a DHS or OHA employee, through decision, approval, disapproval, recommendation, the rendering of advice, investigation or otherwise in connection with the Contract.

**(5)** "Personally and substantially" has the same meaning as "personal and substantial" as set forth in 5 CFR 2635.402(b)(4).

**18. Non-Discrimination**

Contractor shall comply, and require its Subcontractors to comply, with all federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities) the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and all amendments to those acts and all regulations promulgated thereunder. Contractor shall also comply with all applicable requirements of State civil rights and rehabilitation statutes and rules.

**19. OASIS**

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Outcome and Assessment Information Set reporting requirements and notice requirements for skilled services provided by Home Health Agencies, pursuant to CMS requirements published in 42 CFR 484.20, and such subsequent regulations as CMS may issue in relation to the OASIS program.

**20. Patient Rights Condition of Participation**

To the extent applicable, Contractor shall comply with, and shall require Subcontractors to comply with, the Patient Rights Condition of Participation that Hospitals must meet to continue participation in the Medicaid program, pursuant to 42 CFR Part 482. For purposes of this Contract, Hospitals include short-term, psychiatric, rehabilitation, long-term, and children's Hospitals.

**21. Federal Grant Requirements**

The federal Medicaid rules establish that OHA is a recipient of federal financial assistance, and therefore is subject to federal grant requirements pursuant to 42 CFR 430.2(b). To the extent applicable to Contractor or to the extent OHA requires Contractor to supply information or comply with procedures to permit OHA to satisfy its obligations federal grant obligations or both, Contractor shall comply with the following parts of 45 CFR:

**a.** Part 74, including Appendix A (uniform federal grant administration requirements);

**b.** Part 92 (uniform administrative requirements for grants to state, local and tribal governments);

**c.** Part 80 (nondiscrimination under Title VI of the Civil Rights Act);

**d.** Part 84 (nondiscrimination on the basis of handicap);

**e.** Part 91 (nondiscrimination on the basis of age);

**f.** Part 95 (Medicaid and CHIP federal grant administration requirements); and

**g.** Contractor shall not expend, and Contractor shall include a provision in any Subcontract that its Subcontractor shall not expend, any of the funds paid under this Contract for roads, bridges, stadiums, or any other item or service not covered under the OHP.

**22. 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.

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

## Exhibit F – Insurance Requirements

**Required Insurance:** Contractor shall obtain at Contractor's expense the insurance specified in this Ex. F, prior to performing under this Contract, and shall maintain it in full force and at its own expense throughout the duration of this Contract. Contractor shall obtain the following insurance from insurance companies or entities that are authorized to transact the business of insurance and issue coverage in the State of Oregon and that are acceptable to OHA.

### 1. Workers' Compensation

All employers, including Contractor, that employ subject workers who work under this Contract in the State of Oregon shall comply with ORS 656.017 and provide the required Workers´ Compensation coverage, unless such employers are exempt under ORS 656.126. Contractor shall ensure that each of its Subcontractors complies with these requirements.

### 2. Professional Liability

Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this Contract, professional Liability Insurance covering any damages caused by an error, omission or any negligent acts related to the services to be provided under this contract by the Contractor and Contractor's Subcontractors, agents, officers and employees in an amount of not less than $2,000,000 per occurrence, incident or claim. Annual aggregate limit shall not be less than $4,000,000. If coverage is on a claims made basis, then either an extended reporting period of not less than 24 months shall be included in the professional Liability Insurance coverage, or the Contractor shall maintain either tail coverage or continuous claims made liability coverage, provided the effective date of the continuous claims made coverage is on or before the effective date of this Contract, for a minimum of 24 months following the later of (i) Contractor's completion and OHA's acceptance of all Services required under this Contract, or, (ii) OHA or Contractor termination of contract, or, (iii) the expiration of all warranty periods provided under this Contract.

### 3. Commercial General Liability

Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this Contract, commercial general Liability Insurance covering bodily injury and property damage in a form and with coverages that are satisfactory to OHA. This insurance shall include personal and advertising injury liability, products and completed operations and contractual liability coverage for the indemnity provided under this contract. Coverage shall be written on an occurrence basis in an amount not less than $1,000,000 per occurrence. Annual aggregate limit shall not be less than $2,000,000.

### 4. Automobile Liability

Contractor shall obtain, at Contractor's expense, and keep in effect during the term of this contract, automobile Liability Insurance covering Contractor's business use including coverage for all owned, non-owned, or hired vehicles with a combined single limit of not less than $1,000,000 for bodily injury and property damage. This coverage may be written in combination with the commercial general Liability Insurance (with separate limits for commercial general liability and automobile liability).

### 5. Network Security and Privacy Liability

Contractor shall provide network security and privacy Liability Insurance for the duration of the Contract and for the period of time in which Contractor (or its Business Associates or Subcontractor(s)) maintains, possesses, stores or has access to OHA or client data, whichever is longer, with a combined single limit per claim or incident of no less than the limit provided in the table below that corresponds to Contractor's average monthly Member Enrollment. This insurance shall include coverage for third party claims and for losses, thefts, unauthorized disclosures, access or use of OHA or client data (which may include, but is not limited to, Personally Identifiable Information ("PII"), Payment Card Data and Protected Health

Information ("PHI")) in any format, including coverage for accidental loss, theft, unauthorized disclosure access or use of OHA data.

| Contractor's Average Monthly Member Enrollment | Minimum Combined Single Limit per Claim or Incident |
|---|---|
| 1 to 49,000 | $1,000,000 |
| 49,001 to 74,000 | $2,000,000 |
| 74,001 to 149,000 | $3,000,000 |
| 149,001 to 249,000 | $4,000,000 |
| 249,001 to 349,000 | $5,000,000 |
| 349,001 to 449,000 | $6,000,000 |

**6. Excess/Umbrella Insurance**

A combination of primary and excess/umbrella insurance may be used to meet the required limits of insurance.

**7. Additional Insured**

The commercial general Liability Insurance and automobile Liability Insurance required under this Contract shall include the State of Oregon, its officers, employees and agents as Additional Insureds but only with respect to Contractor's activities to be performed under this Contract. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

**8. Administrative Notice of Cancellation or Change**

Contractor shall assure that no cancellation, material change, potential exhaustion of aggregate limits or non–renewal of insurance coverage(s) occurs without sixty (60) days prior written notice from Contractor or its insurer(s) via Administrative Notice to OHA.

**9. Proof of Insurance**

Contractor shall provide to OHA information requested in 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 pay for all deductibles, self-insured retentions, and self-insurance, if any.

**10. Self-insurance**

Contractor may fulfill one or more of its insurance obligations herein through a program of self-insurance, provided that Contractor's self-insurance program complies with all Applicable Laws, provides coverage equivalent in both type and level to that required in this Ex. F, and is reasonably acceptable to OHA. Notwithstanding Sec. 9 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.

## Exhibit G – Reporting of Delivery System Network Providers and Cooperative Agreements

### 1. Delivery System Network Provider Monitoring and Reporting Overview

**a.** Contractor shall employ or Subcontract with, as required under 42 CFR § 438.206, Ex. B, Part 4 and any other applicable provisions of this Contract, enough Providers to meet the needs of its Members in all categories of service, and types of service Providers, such that Members have timely and appropriate access to services. Contractor shall develop its Provider Network that is consistent with 42 CFR § 438.68, 42 CFR § 457.1230, and OAR 410-141-3515 such that Contractor's Provider Network is capable of providing integrated and coordinated Oral Health 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 Oral Health and specialty care 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, or as a result of OHA Monitoring, or EQRO review.

**f.** The accuracy of data and completeness submitted in the quarterly 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 monthly 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 quarterly DSN Provider Capacity Report no later than forty-five (45) days following the end of each calendar quarter. Contractor shall provide OHA with an annual DSN Narrative Report by July 31 of each Contract Year for the 12-month period ending on the immediately preceding June 30. In addition, Contractor shall submit an updated DSN Provider Capacity Report any time there is a Material Change. Contractor shall utilize the DSN Provider Capacity and Narrative Report templates located on the DCO Contract Forms Website. Contractor shall provide the Reports to OHA via Administrative Notice.

**(1)** All of Contractor's Participating Providers must be included in the DSN Provider Capacity Report. Contractor shall also include the names of any and all Providers terminated from Contractor's Provider Network, the reason for each such termination, the number of Members impacted by the Provider termination(s), and any other information required to be included as identified in the DSN Provider Capacity Report template. This reporting

requirement is in addition to the reporting requirements set forth in the applicable provisions of Ex. B, Part 3 and Ex. B, Part 9 and any other reporting requirements under this Contract regarding terminated Providers.

**(2)** Each quarterly 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 DCO Contract Forms Website.

**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 Oral Health and specialty care 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 annual integrated DSN Provider Narrative Report that includes comprehensive narrative responses and analysis demonstrating 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 Report, Contractor shall provide information that corresponds with the categories described below, the details of which are specified in the Guidance Document provided on the DCO Contact Forms Website.

**(1)** Description of the Delivery Network and Adequacy.

**(2)** DSN Time and Distance Standards.

**(3)** Description of Members and Member Needs.

**(4)** Coordination of Care.

**(5)** Performance on Metrics.

**d.** Contractor shall also include in the annual DSN Narrative Report a description of current barriers to network adequacy, gaps in Contractor's Provider Network identified during the 12-month period, and how they were addressed or how Contractor intends to resolve those deficiencies including the following:

**(1)** The methodology used to identify barriers and network gaps;

**(2)** Immediate short-term interventions to correct network gaps;

**(3)** Long-term interventions to fill network gaps and resolve barriers;

**(4)** Outcome measures for evaluating the efficacy of interventions to fill network gaps and resolve barriers;

**(5)** Projection of changes in future capacity needs; and

**(6)** Ongoing activities for network development based on identified gaps and future needs projection.

**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: 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.

# Exhibit H – RESERVED

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

# Exhibit I – Grievance and Appeal System

Contractor's Grievance and Appeal System shall consist of the processes Contractor follow with respect to Grievances, Adverse Benefit Determinations, Appeals of Adverse Benefit Determinations, resolutions of Appeals, and access to Contested Case Hearing, as well as the processes to collect and track information about these processes, in accordance with OAR 410-141-3875 through OAR 410-141-3915, OAR 410-120-1860, 42 CFR § 438.400 through § 438.424, this 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. c-h and Sec. 5 of Ex. B, Part 3 of this Contract.

**(2)** Contractor shall permit Members to file a Grievance orally or in writing at Member's option.

**(3)** Contractor shall permit Members to file an Appeal orally or in writing, consistent with the requirements in OAR 410-141-3890.

**(4)** Contractor shall treat an oral request for Appeal of an Adverse Benefit Determination as an Appeal and shall establish the filing date as the date when there is established contact made between the Member and Contractor pertaining to the request.

**(5)** Contractor shall provide, in accordance with 42 CFR § 438.406, Members with all reasonable assistance in completing forms and taking other procedural steps in connection with Grievances, Appeals, and Contested Case Hearings. This assistance must include, but is not limited to, providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability free of charge to each Member.

**(6)** Contractor shall not discourage any Member from using any aspect of the Grievance and Appeal System. Nor shall Contractor:

**(a)** Encourage any Member to withdraw a Grievance, Appeal, or Contested Case Hearing request already filed;

**(b)** Use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a Member or as a basis for requesting Member Disenrollment, or

**(c)** Take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal.

**(7)** Contractor shall make Grievance and Appeal forms, including those listed in OAR 410-141-3890, available and accessible to Members in all administrative offices.

**(8)** Individuals who make decisions on Grievances and Appeals must be individuals who:

**(a)** Were not involved in any previous level of review or decision-making with respect to the Grievance or Appeal;

**(b)** Were not a subordinate of an individual involved in any previous level of review or decision-making with respect to the Grievance or Appeal; and

**(c)** Have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease when deciding any of the following:

**i.** An Appeal of a denial that is based on lack of Dental necessity;

**ii.** A Grievance regarding denial of expedited resolution of an Appeal; or

**iii.** A Grievance or Appeal that involves clinical issues.

**(9)** Contractor's Appeal process shall take into account all comments, documents, records, and other information submitted by Member 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 DCO 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 DCO, as such term is defined in OAR 410-141-3850,[24] 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 DCO 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

[24] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

OHA's Ombudsperson as expeditiously as the affected Member's health condition requires, and within timeframes set forth in or required by this Contract.

**e.** Contractor shall conduct analysis of its Grievances in the context of Quality Improvement activity, consistent with OAR 410-141-3875 and incorporate the analysis into the quarterly data provided to OHA under this Contract.

**f.** Contractor shall resolve each Grievance and provide notice to the Member of the disposition as expeditiously as the Member's health condition requires within the following timeframes and meeting the following requirements:

**(1)** **Resolution for Grievances**. Contractor shall provide written notice to the Member, within five (5) Business Days from the date of Contractor's receipt of the Grievance, acknowledging receipt of the Grievance and of one of the following:

**(a)** A decision on the Grievance has been made and what that decision is; or

**(b)** Contractor's decision will not exceed thirty (30) calendar days from the date of Contractor's receipt of the Grievance, and the reason additional time is necessary. 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 a written Notice of Adverse Benefit Determination.

**a.** Contractor's NOABD must comply with all of the following requirements:

**(1)** Meet the language and format requirements in Secs. 4 and 5 of Ex. B, Part 3 of this Contract and be consistent with the requirements of OAR 410-141-3580, 410-141-3585 and 42 CFR § 438.10, including, without limitation, translating a NOABD for those Members who speak Prevalent Non-English Languages.

**(2)** Include all of the following information for *pre-service* denials:

(a) Language access statement clarifying that oral interpretation is available for all languages and how to access it and a non-discrimination statement stating that Contractor may not treat Members unfairly due to their age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation;

(b) Contractor's contact information including name, address, and telephone number;

(c) Date of the notice;

(d) Name of the Member's Primary Care Provider (PCP), Primary Care Dentist (PCD), or Behavioral Health professional if the Member has an assigned practitioner. If the Member has not yet been assigned a practitioner due to recent enrollment, the NOABD should state that PCP, PCD, or Behavioral Health professional assignment has not occurred;

(e) Member's name, date of birth, address, and OHP ID number;

(f) Description and explanation of the service(s) requested and the Adverse Benefit Determination the Contractor intends to make, including whether the Contractor is denying, terminating, suspending, or reducing a service;

(g) Date the service was requested by the Provider or Member;

(h) Name of the Provider who requested the service;

(i) Effective date of the Adverse Benefit Determination if different from the date of the NOABD;

(j) Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if the Contractor is denying a requested service because of line placement on the Prioritized List or the diagnosis and procedure code do not pair on the Prioritized List;

(k) Other conditions Contractor considered including but not limited to: co-morbidity factors if the service was below the funding line on the Prioritized List; statement of intent governing the use and application of the Prioritized List to requests for health care services including the placement of the condition/diagnosis code on the Prioritized List; and other coverage for services addressed in the State 1115 Waiver;

(l) Clear and thorough explanation of the specific reasons for the Adverse Benefit Determination;

(m) A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the NOABD;

**(n)** The Member's right or, if the Member provides written consent as required under OAR 410-141-3890(1), the Provider's right to file a written or oral Appeal of Contractor's Adverse Benefit Determination with Contractor, including information on exhausting Contractor's one level of Appeal, and the procedures to exercise that right;

**(o)** The Member's or the Provider's right to request a Contested Case Hearing with OHA only after Contractor's Notice of Appeal Resolution or where Contractor failed to meet Appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

**(p)** The circumstances under which an expedited Appeal resolution and an expedited Contested Case hearing are available and how to request;

**(q)** The Member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of the services;

**(r)** The Member's right to receive from Contractor, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's Adverse Benefit Determination; and

**(s)** Copies of the appropriate forms as listed in OAR 410-141-3885.

**(3)** Include all of the following information for *post-service* denials:

**(a)** Language access statement clarifying that oral interpretation is available for all languages and how to access it and a non-discrimination statement stating that Contractor may not treat Members unfairly due to their age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation;

**(b)** Date of the notice;

**(c)** Contractor name, address and phone number;

**(d)** Name of the Member's Primary Care Provider (PCP), Primary Care Dentist (PCD), or Behavioral Health professional if the Member has an assigned practitioner. If the Member has not yet been assigned a practitioner due to recent enrollment, the NOABD should state that PCP, PCD, or Behavioral Health professional assignment has not occurred;

**(e)** Member's name, address, OHP ID number, and date of birth;

**(f)** Description and explanation of the service(s) previously provided and an explanation of the Adverse Benefit Determination that Contractor to make, including whether Contractor is denying, terminating, suspending, or reducing a service or denying a payment for a service in whole or in part;

**(g)** Date the service was provided;

**(h)** Name of the Provider who performed the service;

**(i)** Effective date of the Adverse Benefit Determination if different from the date of the NOABD;

(j) Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if the Contractor is denying a requested service because of line placement on the Prioritized List or the diagnosis and procedure code do not pair on the Prioritized List;

**(k)** Other conditions Contractor considered including but not limited to co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services; statement of intent governing the use and application of the Prioritized List to requests for health care services including the placement of the condition/diagnosis code on the Prioritized List; and other coverage for services addressed in the State 1115 Waiver;

**(l)** Clear and thorough explanation for the specific reasons for the Adverse Benefit Determination;

**(m)** A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the NOABD;

**(n)** The Member's right or, if the Member provides written consent as required under OAR 410-141-3890(1), the Provider's right to file a written or oral Appeal of Contractor's Adverse Benefit Determination with Contractor, including

information on exhausting Contractor's one level of Appeal, and the procedures to exercise that right;

**(o)** The Member's or the Provider's right to request a Contested Case Hearing with OHA only after Contractor's Notice of Appeal Resolution or where Contractor failed to meet Appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;

**(p)** Explanation to the Member that there are circumstances under which an Appeal process or Contested Case Hearing can be expedited, and the procedures to request that right, but that an expedited Appeal and Hearing will not be granted for post-service denials as the service has already been provided;

**(q)** The Member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of the services;

**(r)** The Member's right to receive from Contractor, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's Adverse Benefit Determination;

**(s)** Statement that the Provider cannot bill the Member for a service rendered unless the Member signed an OHP Agreement to Pay form (OHP 3165 or 3166); and

**(t)** Copies of the appropriate forms as listed in OAR 410-141-3885.

**b.** Contractor shall, for every NOABD, meet the following timeframes:

**(1)** For termination, suspension, or reduction of previously authorized Covered Services:

**(a)** The NOABD shall be mailed at least ten (10) days before the date of the Adverse Benefit Determination, except as permitted under Ex. I, Sec. 3, Para. b, Sub. Para. (1) (b) and (c).

**(b)** The NOABD may be mailed less than ten (10) days prior to, but in no event later than, the date the Adverse Benefit Determination takes effect if:

**i.** Contractor has factual information confirming the death of the Member;

**ii.** Contractor receives a clear, written statement signed by the Member that the Member no longer wishes services or gives information that requires termination or reduction of services and indicates that the Member understands that termination or reduction of services will be the result of supplying the information;

**iii.** Contractor can verify the Member has been admitted to an institution where the Member is ineligible for Covered Services from Contractor;

**iv.** The Member's whereabouts are unknown and Contractor receives a notice from the post office indicating no forwarding address and OHA has no other address;

**v.** Contractor verifies another state, territory, or commonwealth has accepted the Member for Medicaid services;

**vi.** The Member's PCP, PCD, or Behavioral Health professional prescribed a change in the level of health services;

**vii.** There is an Adverse Benefit Determination made with regard to the preadmission screening requirements for LTPC admissions; or

**viii.** For Adverse Benefit Determinations for LTPC transfers, the safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent Dental 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.

**(3)** For Prior Authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested and are standard authorization decisions:

**(a)** The NOABD shall be mailed as expeditiously as the Member's health condition requires and in all cases not later than fourteen (14) calendar days following receipt of the request for service, except that:

**i.** Contractor may have an extension of up to fourteen (14) additional days if the Member or the Provider requests the extension or when Contractor can justify that a need for additional information and how the extension is in the Member's interest; Contractor shall provide its justification to OHA, via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request.

**ii.** If Contractor extends the timeframe, in accordance with 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, 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 410-141-3245 3875 Contractor shall inform the Member of the amount of time available to present evidence and argument sufficiently in advance of the resolution timeframe for Appeals as specified in 42 CFR § 438.408(b) and (c).

**(4)** Provide Appeal information to Members in accordance with 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.

**(5)** Include as parties to the Appeal:

**(a)** The Member and the Representative;

**(b)** A Provider acting on behalf of a Member, with written consent from the Member;

**(c)** Contractor; and

**(d)** The legal Representative of a deceased Member's estate.

**(6)** Contractor shall document and maintain a record of each Appeal as described in OAR 410-141-3875 and OAR 410-141-3915.

**b. Appeal Resolution and Notification**

**(1) General Requirements for Resolution**

**(a)** Contractor shall resolve each Appeal, and provide notice to Members, as expeditiously as their health condition requires and within the timeframes in this Ex. I, Sec. 4.

**(b)** If Contractor fails to adhere to the notice and timing requirements in 42 CFR § 438.408, Contractor shall consider the affected Member to have exhausted the Appeals process and allowed to initiate a Contested Case Hearing.

**(2) Standard Resolution for Appeals**

**(a)** Contractor shall resolve standard Appeals as expeditiously as a Member's health condition requires and no later than sixteen (16) days from the day Contractor receives the Appeal. Contractor may extend this timeframe by up to fourteen (14) days if:

**i.** The Member requests the extension; or

**ii.** Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the affected Member's interest.

**(b)** If Contractor extends the timeframes, it shall, for any extension not requested by a Member, give the Member a written notice, and make reasonable effort (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 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 Notice of Hearing Rights (DMAP 3030) available at https://sharedsystems.dhsoha.state.or.us/forms/ and the Hearing Request Form (MSC 0443) or Appeal and Hearing Request (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx.

**iii.** 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 Contractor has completed the initial plan appeal, Contractor shall:

**i.** Date-stamp the hearing request with the date of receipt; and

**ii.** Submit the following required documentation to OHA within two Business Days:

**A.** Copies of the Contested Case Hearing request, Notice of Adverse Benefit Determination, and Notice of Appeal Resolution; and

**B.** All documents and records the MCE relied upon to take its action, including those used as the basis for the initial action or the Notice of Appeal Resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

## 5. Contested Case Hearings

Contractor's Grievance and Appeal System shall provide Contractor's Members access to a Contested Case Hearing before OHA. Members must complete Contractor's Appeal process prior to receiving a hearing with OHA. In any case where a Contractor fails to adhere to the notice or timing requirements set forth in OAR 410-141-3875 through 410-141-3895, the Member is deemed to have exhausted the Contractor Appeals process and may initiate a Contested Case Hearing. If a Participating Provider filed an appeal on behalf of Member as permitted by OAR 410-141-3890, the Participating Provider must be allowed to request a Contested Case Hearing on behalf of Member. Contractor shall also, in accordance with 42 CFR § 438.406(a), provide all reasonable assistance to Members in completing forms and taking other procedural steps related to the Contested Case Hearing process. Contractor's Grievance and Appeal System must provide for the following as described in OAR 410-141-3900 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**

If, at the Member's request, the Contractor continues or reinstates the Member's benefits while the Appeal is pending, pursuant to 42 CFR § 438.420(c) and OAR 410-141-3910 the benefits must be continued until one of the following occurs:

**(a)** The Member withdraws the Appeal; or

**(b)** The Contractor issues an Appeal Resolution.

**(2) Continuation of benefits pending Contested Case Hearing resolution**

If, at the Member's request, Contractor continues or reinstates the Member's benefits while the Contested Case Hearing is pending, pursuant to 42 CFR § 438.420(c) 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 when Contractor mails the Notice of Appeal Resolution letter

**(b)** The Member withdraws their Request for Contested Case Hearing; or

**(c)** A final Contested Case Hearing decision adverse to the Member is issued.

**d. Member responsibilities for services furnished while the Appeal or Contested Case hearing is pending**

If the final resolution of the Appeal or Contested Case Hearing upholds Contractor's Adverse Benefit Determination, Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal or hearing was pending pursuant to 42 CFR § 431.230(b) 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**

**a. Services not furnished while an Appeal is pending**

If Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal or Contested Case Hearing was pending, Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date Contractor receives the decision reversing the Adverse Benefit Determination.

**b. Services furnished while an Appeal is pending**

If Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the disputed services were furnished while the Appeal or Contested Case Hearing was pending, Contractor shall pay for the services.

**8. Final Order on Contested Case Hearings**

OHA will resolve a Contested Case Hearing ordinarily within ninety (90) days from the date Contractor receives the Member's request for Appeal. This does not include the number of days the Member took to subsequently file a Contested Case hearing request. The final order is the final decision of OHA.

**9. Record Keeping and Quality Improvement**

**a.** Contractor shall document and maintain a record of all Member Grievances and Appeals in accordance with OAR 410-141-3890, OAR 410-141-3915, OAR 410-141-3875, and 42 CFR §

438.416. Contractor shall fully and timely comply with all records requests. Contractor shall fully and promptly comply with OHA Monitoring and oversight.

**b.** Contractor shall maintain 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. OHA Review and Approval of Grievance and Appeal System, Policies and Procedures, and Member Notice Templates**

**a.** The following apply to the review and approval or disapproval of Contractor's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System:

**(1)** Contractor shall annually review, and if necessary, update its Grievance and Appeal System, policies and procedures related thereto, and Member notice templates. Contractor shall provide OHA's Contract Administrator, via Administrative Notice, with Contractor's Grievance and Appeal System for review and approval by March 1 of each Contract Year. If no changes have been made to Contractor's Grievance and Appeal System policies and procedures or Member notice templates or both since last approved by OHA, Contractor may, for its annual March 1 submission, submit to OHA via Administrative Notice, an Attestation stating that no changes have been made.

**(2)** At the time Contractor makes any changes to the approved Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, Contractor shall provide OHA's Contract Administrator with Administrative Notice that identifies proposed changes with particularity and when applicable includes the revised Grievance and Appeal System or any other documents relating thereto.

**(3)** Within five (5) Business Days after the request of OHA, including but not limited to requests in connection with or following a quarterly review pursuant to this Ex. I, Sec. 10, Para. b, or to requests in connection with or following a Contested Case Hearing, Contractor shall provide OHA, via Administrative Notice, Contractor's Grievance and

Appeal System, policies and procedures related thereto, Member notice templates, or any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, to OHA for compliance review. Without limiting any other provision in this Contract, in the event OHA, CMS, or EQRO determine Contractor's Grievance and Appeal System Member template notices do not comply with Applicable Laws, or with the terms and conditions of this Contract. Contractor shall revise such Member template notices within thirty (30) days of notification by OHA, CMS, or EQRO of non-compliance and submit them to OHA, via Administrative Notice, for review and approval or disapproval.

**(4)** Contractor shall obtain OHA approval of Member materials included in Contractor's Grievance and Appeal system, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System prior to implementing and providing such materials to Members.

**(5)** Within forty-five (45) days from the annual due date, or within forty-five (45) days from the received date if after the annual due date, of Contractor's Grievance and Appeal System or, for changes made outside of the annual submission, within forty-five (45) days from receipt of changes to Contractor's approved Grievance and Appeal System, policies and procedures related thereto, Member notice templates, or any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, OHA will provide Contractor's Contract Administrator with Administrative Notice of OHA's approval or disapproval of Contractor's Grievance and Appeal System. OHA will notify Contractor within the same forty-five (45) day period if additional time is needed for review. OHA may disapprove of all or part of Contractor's Grievance and Appeal System based on any failure to comply with this Contract and any other the Applicable Laws. In the event OHA does not approve Contractor's Grievance and Appeal System, Contractor shall follow the process set forth in Sec. 5, Ex. D to this Contract.

**(6)** Upon approval, Contractor's Grievance and Appeal System, policies and procedures related thereto, Member notice templates, and any other documents to be provided to Members regarding Contractor's Grievance and Appeal System, must be included in Contractor's Member Handbook (as indicated in OHA's Member Handbook Evaluation Criteria located on the DCO 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)** A Grievance and Appeal Log in a format provided by OHA and available at on the DCO Contract Forms Website. Contractor's obligation to submit its final quarterly Grievance and Appeal Log shall survive termination or expiration of this Contract;

**(2)** Samples of NOABD and corresponding Prior Authorization documentation. Contractor's Prior Authorization template shall include, at a minimum: date of the request for the service, the diagnosis codes, including but not limited to medical, dental, behavioral, and transportation billing codes, submitted, the CPT or HCPCS (treatment) codes being requested, and any comorbid diagnosis codes that the Provider may list on the authorization request. OHA will randomly select samples from Contractor's Grievance and Appeal log for the corresponding quarter for review. The sample size per quarter is a minimum of twenty samples and a maximum of samples numbering up to ten percent (10%) of the number of NOABDs issued during the quarter. Contractor shall submit records for the

samples selected by OHA in the manner directed by OHA in its request no later than fourteen (14) days following receipt of OHA's request;

and

**(3)** Any other related documentation requested by OHA.

**c.** Within forty-five (45) days after the end of each calendar quarter, Contractor shall provide its Grievance System Report to OHA via Administrative Notice. Such Grievance System Report shall be in a format provided by OHA which is available on the DCO Contract Forms Website. Contractor shall use data collected from its own and its Subcontractors' Monitoring of Contractor's Grievance and Appeal System, including the Grievance and Appeal data reported by Contractor and Subcontractors in their Grievance and Appeal logs to analyze such system. Contractor shall demonstrate how Contractor uses the data it has collected for itself and its Subcontractors to maintain an effective process for Monitoring, evaluating, and improving the access, quality and appropriateness of services provided to Members. Contractor's obligation to submit its final quarterly Grievance System Report shall survive termination or expiration of this Contract.

**d.** Contractor shall promptly comply with all Grievance and Appeal records requests from OHA, CMS, EQRO, and any of their designees. Contractor shall submit, in accordance with such request, records to OHA's Contract Administrator, no later than fourteen (14) days following Contractor's receipt of a request, except where a request is related to a Contested Case Hearing, in which case Contractor shall submit required documentation within twenty-four (24) hours for an expedited hearing and two (2) days for a non-expedited hearing. Contractor is responsible for collecting and submitting the Grievance and Appeal records maintained in part or in full by Subcontractors. Contractor shall revise Grievance and Appeal Systems within thirty (30) days of notification by CMS, OHA, or EQRO of non-compliance with this Contract, and Applicable Laws. 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.

**e.** Contractor shall review for completeness and accuracy the data collected from the Grievance and Appeal Systems of Contractor and its Subcontractors, on a monthly basis, and provide the results of such review to OHA, federal, state, and OHA contracted auditors upon request.

**f.** If Contractor has Delegated, in part or in full, Monitoring of any Grievance and Appeal System to a Subcontractors or Participating Providers, Contractor shall submit records of such Monitoring to OHA, federal, state, and OHA contracted auditors, upon request. Such Subcontractor or Participating Provider records shall provide evidence of compliance, as required under 42 CFR § 438.230, with provisions in this Contract under OAR 410-141-3835 through 410-141-3915, and 42 CFR §§ 438.400 through 438.424 and this Ex. I. The records submitted under Ex. I, Sec. 10, Para. f. of this Contract shall include any Corrective Actions initiated by Contractor as a result of Subcontractor or Participating Provider Monitoring, up to and including termination of Subcontractor or Participating Provider. Contractor shall submit all records requested under Ex. I, Sec. 10, Para. f. of this Contract to OHA, via Administrative Notice, no later than fourteen (14) days following receipt of the request or in a timeframe established by the requesting entity.

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# Exhibit J – Health Information Technology

## 1. Health Information Technology Requirements

**a.** Contractor shall maintain a Health Information System that: i) meets the requirements of this Contract; ii) meets the requirements of 42 CFR § 438.242 and section 1903(r)(1)(F) of PPACA; and iii) collects, analyzes, integrates and reports data that can provide information on areas including but not limited to:

**(1)** Names and phone numbers of the Member's Primary Care Dentist or clinic;

**(2)** Evidence that the Member has been informed of rights and responsibilities;

**(3)** Grievance, Appeal and Contested Case Hearing records;

**(4)** Utilization of services;

**(5)** Disenrollment for other than loss of Medicaid eligibility;

**(6)** Covered Services provided to Members, through Encounter Data system or other documentation system; and

**(7)** 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.

**(8)** Those Provider characteristics required to be collected under Ex. G to this Contract;

**(9)** Member Enrollment; and

**(10)** 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. 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 OAR 410-141-3591.[25] The provisions of the CMS Interoperability and Patient Access Final Rule, with which Contractor is required to comply are: 42 CFR § 438.242(b)(5)-(6), 42 CFR § 457.1233(d), 42 CFR § 438.62(b)(1)(vi) & (vii). These rules include requirements relating to the: (i) use of application programming interfaces (APIs) to: (y) provide patient access to payer claims, encounter information, and costs, and (z) make managed care plans' Provider directories publicly available; and (ii) exchange of certain patient clinical data between payers.

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[25] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

## Exhibit K – Health Equity

Contractor must have an organizational infrastructure; workforce capacity with competence in relevant skill sets; and any other relevant policies, systems, and processes necessary to develop and execute Health Equity strategies.

### 1. Health Equity Assessment

To inform OHA about Contractor's organizational capacity to meet Health Equity requirements, Contractor must complete a Health Equity Assessment of its infrastructure and capacity to advance Health Equity as an organization and at Service Area levels. Contractor's Health Equity Assessment shall include the elements identified in this Section and be developed utilizing OHA's Health Equity Assessment Guidance Documents and, if requested by Contractor, with technical assistance from OHA. The Health Equity Assessment Guidance Documents are located on the DCO Contract Forms Website.

**a.** Development of Health Equity Assessment

**(1)** The Health Equity Assessment submitted in Contract Year 2022 will:

**(a)** Serve as a baseline measure of selected components' capacity, skills, and areas for improvement to support Health Equity focused activities;

**(b)** Provide an inventory of the presence of organizational and staff-level traits that support the ability to perform effective Health Equity-focused work;

**(c)** Provide information about current capacity for Health Equity activities; and

**(d)** Provide evidence of organizational readiness, assets, and gaps, and provide an assessment of Contractor's progress towards organizational development of Health Equity infrastructure and capacity and to target technical assistance.

**(2)** Contractor shall submit the baseline Health Equity Assessment to OHA, via Administrative Notice, by no later than April 29, 2022.

**(3)** The CY 2022 Health Equity Assessment will be used to develop additional Contract requirements for subsequent years. In subsequent years, OHA will use the annual Health Equity Assessment to assess Contractor's progress with respect to implementation of the strategies, tasks, and activities for each area of the Health Equity Assessment.

### 2. Organizational and Provider Network Cultural Responsiveness and Implicit Bias Training and Education Plan Requirements

**a.** As set forth in further detail below in this Section, Contractor shall incorporate and require Cultural Responsiveness and implicit bias continuing education and trainings into its existing organization-wide employee training plans and programs.

**b.** Contractor may elect, but it is not required, to offer Cultural Responsiveness and implicit bias trainings to its Provider Network.

**c.** Cultural Competence trainings offered by Contractor to its employees and, if applicable, Provider Network must align with the components of a Cultural Competence curriculum set forth by OHA's Cultural Competency Continuing Education criteria listed on OHA's website located at: https://www.oregon.gov/oha/OEI/Documents/OHA%20CCCE%20Criteria_May2019.pdf.

Contractor may utilize OHA pre-approved Cultural Competence Continuing Education trainings to meet its obligations under this Section, which are provided on the OHA website located at: https://www.oregon.gov/oha/OEI/Documents/CCCE%20Registry_041919.pdf.

However, Contractor may develop its own Cultural Competence curricula and trainings subject to: (i) alignment with the cultural competencies identified in the "Criteria for Approval Cultural

Competence Continuing Education Training" document located in the URL above, and (ii) prior written approval by OHA. Contractor must submit a request for approval to OHA via Administrative Notice. For all other trainings, Contractor should ensure quality trainings are offered to its employees and, if applicable, Provider Network.

**d.** Contractor shall attest, in the manner specified by OHA in the associated Guidance Documents, to its adoption of the definition of Cultural Competence set forth in OAR 943-090-0010 and utilize such definition to guide its development of cultural responsiveness materials and topics in its Cultural Competence Continuing Education training activities into its training plans for organizational employees. Such attestation shall accompany the submissions specified in Paras. i. and j. below due by December 1 of each Contract Year.

**e.** Contractor shall ensure that all of its employee training offerings (and any Cultural Competence and implicit bias training Contractor may offer to its Provider Network) include all or a subset of the fundamental areas listed below.

**(a)** Implicit bias/addressing structural barriers and systemic structures of oppression;

**(b)** Language access (including the use of plain language) and use of Health Care Interpreters, including without limitation, the use of Certified or Qualified Health Care and American Sign Language Interpreters;

**(c)** The use of CLAS Standards in the provision of services. Additional information may be found at the following URL: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf;

**(d)** As related to Oral Health care, adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma;

**(e)** Specific to Contractor and Dental Provider requirements, use of REALD data to advance Health Equity;

**(f)** As related to Oral Health care, universal access and accessibility in addition to compliance with the American Dental Association; and

**(g)** Oral Health literacy of population to ensure information is delivered in an accessible and culturally and linguistically appropriate manner.

**f.** Contractor shall provide and require all of its direct employees (e.g., directors, executives, Providers) to participate in all such trainings.

**g.** Contractor shall incorporate fundamental areas of Cultural Responsiveness and implicit bias training (i.e., non-discrimination policy, language access requirements, universal access and accessibility) and trainings relating to the use of healthcare interpreters, including Certified and Qualified Health Care Interpreters, in all new employee orientations. In addition, over the course of employment and beginning upon hiring, Contractor shall provide and require all new employees to receive training and educational activities that address the fundamental areas of Cultural Responsiveness, implicit bias, and the use of health care interpreters.

**h.** Consistent with Sec. 2, Para. b. above, Contractor may provide Cultural Responsiveness and implicit bias training resource options to its Provider Network. If offered, cultural competency trainings must comply with the requirements set forth in Sec. 2, Para c. Contractor shall also require its Provider Network to comply with all of the reporting requirements set forth in this Section; however, such reporting shall be made to Contractor and Contractor will, in turn, incorporate its Provider Network reporting into Contractor's reports, as required under Paras. i.-j. below, in such a manner

that will enable OHA to identify Contractor's and its Provider Network's compliance with this Section.

**i.** Contractor shall provide written documentation to OHA of the Cultural Responsiveness and other related education and training that it will provide in the upcoming year to its employees and any training it elects to offer to the Provider Network. The documentation shall include a timeline, as determined by Contractor, for providing all education and training activities, goals and objectives, and evidence Contractor's adoption of the criteria and core competencies set forth in this Section. Such documentation shall be provided to OHA with the Annual Training and Education Report, via Administrative Notice, by no later than December 1 of each Contract Year.

**j.** Contractor shall also provide OHA with an Annual Training and Education Report that documents all of the previous Contract Year's training activities, including, without limitation, reporting of training subjects, content outlines and materials, assessment of goals and objectives, target audiences, delivery system, evaluations, training dates and hours, training attendance, and trainer qualifications. Contractor shall also include in its Annual Training and Education Report its training and education plan for the then-current Contract Year. The plan shall include trainings required under Paras. (a) - (h) above of this Section. The Annual Training and Education Report shall be provided to OHA, via Administrative Notice, no later than December 1 of each Contract Year. OHA shall have the right to review and approve Contractor's annual employee training and education plan specified above in Para i. for compliance with this Section 2. In the event OHA does not approve Contractor's training and education plan for its employees, Contractor shall follow the process set forth in Sec. 5 of Ex. D of this Contract. The Annual Training and Education Report Guidance Documents are located on the DCO Contract Forms Website.

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## Exhibit L – Solvency Plan and Financial Reporting

### 1. Overview of Solvency Plan

**a.** Background/Authority

**(1)** Contractor shall maintain sound financial management procedures and demonstrate to OHA through proof of financial responsibility that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract. As part of the proof of financial responsibility, Contractor shall provide assurance satisfactory to OHA that Contractor's provisions against the risk of insolvency are adequate to ensure the ability to comply with the requirements of this Contract.

**(2)** Reporting forms and other tools for Contractor's solvency plan and financial reporting are available on the DCO Contract Forms Website and are by this reference incorporated into the Contract.

**b.** Solvency Plan and Financial Reporting

(1) Glossary of Terms

**(a)** Average Fee-For-Service Liability: The Average Monthly Fee-For-Service Liability is the cost of Covered Services that are offered by Contractor to Members that would be owed to creditors in the event of Contractor's insolvency. These are expenditures for Covered Services for which Contractor is at risk and will vary in type and amount. These services may include out-of-area services, primary care services, referral services, and Hospital services. Determination of the cost is based on the usual and customary fee schedule of Contractor and is developed for the anticipated Capitated Services liability. Anticipated monthly non-service liabilities (such as insolvency insurance, hold harmless contracts liabilities, regulated and non-regulated guarantees liabilities, and other liabilities) are not included.

**(b)** Corporate Activity: The financial position of a corporation relating to activities the corporation performs. Includes the OHP line of business. If Contractor is not a corporation it should regard its total OHP Business as Corporate Activity.

**(c)** Net Premiums: Calculation obtained from Report L3.1 which represents Contractor's average OHP Capitation Rate and case rates paid (net of reinsurance premiums paid as applicable) per Member during the reporting period.

**(d)** OHP Business: Activities Contractor performs that relate to this Contract.

**(e)** Quarterly Financial Reports: Financial and utilization information filed quarterly, covering the time periods defined on each report.

**(f)** Receipt of the Appeal: The date that the appeal document is delivered to OHA, Delivery Services Unit and is date-stamped.

### 2. Audited Financial Statements

**a.** Contractor shall submit its annual Audited Financial Statements to OHA for review. In the alternative, and only upon prior written approval of OHA, Contractor may submit an annual Agreed Upon Procedures (AUP) Report to OHA for review. Contractor's Audited Financial Statements or, if applicable its annual AUP Report, shall be provided to OHA through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA. The requirement to submit the annual AUP or Audited Financial Statements shall survive expiration of this Contract and shall be provided to OHA no later than June 30, 2023. Contractor's

Audited Financial Statements, or AUP Report if applicable, shall be prepared by an independent accounting firm and shall include, but are not limited to, the following information:

**(1)** A statement of opinion by the independent accounting firm about the financial statements based on the results of their audit.

**(2)** A statement of opinion by an independent actuarial firm about the assumptions and methods used in determining loss reserve, actuarial liabilities and related items.

**(3)** Balance Sheet. The information specified in Report L5 shall be included in the Audited Annual Balance Sheet of Corporate Activity or the accompanying notes or schedules to Financial Statements. Amounts reported in the annual audit shall equal the amounts previously reported to OHA on Report L5 for the 4th quarter of the calendar year. Contractor shall update the 4th quarter Financial Report for audit adjustments and submit to OHA no later than June 30 following the last day of each calendar year that this Contract is in effect.

**(4)** Statement of Revenue, Expenses and Changes in Net Assets. The information specified in Report L6 CORP shall be included in the Audited Yearly Statement of Revenue, Expenses and Changes in Net Assets or the accompanying Notes to Financial Statements. Amounts reported in the annual audit shall equal the amounts reported to OHA on Report L6 CORP YTD for the 4th quarter of the calendar year. Contractor shall update prior Quarterly Financial Report L6 CORP for audit adjustments and submit to OHA no later than June 30th, following the last day of each calendar year that this Contract is in effect.

**(5)** Statement of Cash Flow. The information specified in Report L7 shall be included in the Audited Cash Flow Analysis for Corporate Activity or the accompanying Notes to Financial Statements. Contractor shall allocate cash flow using the Indirect Method of Accounting, as described by U.S. Generally Accepted Accounting Principles (GAAP).

**(6)** Notes to Financial Statements.

**(7)** Any supplemental information deemed necessary by the independent accounting firm, actuary or OHA.

**(8)** Audited Financial Statements and the accompanying Notes to Financial Statements shall include information specified in Reports L5, L6, and L7 on the Contract Reports Web Site. Contractor shall use U.S. GAAP to define the information requested.

**(9)** Contractor shall disclose to OHA within the notes of the Annual Audited Financial Reports any sale, exchange or lease of any property, any lending of money or other extension of credit and any furnishing for consideration of goods, services or facilities between the Contractor and any party of interest, excluding regular business operation administrative expenses, such as compensation and bonuses made to personnel. Party of interest is defined as (i) any director, officer, partner, affiliate, or employee responsible for management or administration of the Contractor, (ii) any person who is directly or indirectly the beneficial owner of 5% or more of the net worth of the Contractor, (iii) any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the Contractor, or (iv) an incorporator or member of the Contractor entity under applicable state law. Contractor shall make this information available to any Member upon request, with two weeks prior notice. Contractor shall also make this information available, upon request, to the Secretary of DHHS, the Inspector General of the DHHS, and the Comptroller General.

**3.** Quarterly Financial Reports

**a.** Contractor shall report results of financial operations to OHA quarterly unless annotated as an annual requirement only. The reports identified below are available on the DCO Contract Forms Website and shall be referred to collectively as the Quarterly Financial Reports. Definitions and instructions for completing each report identified below have been posted on the DCO Contract Forms Website:

**b.** Quarterly Financial Reports include, but are not limited to, the following:

**(1)** Report L1: General Information and Certification;

**(2)** Report L2: Members Approaching or Surpassing Stop-Loss Deductible;

**(3)** Report L3: Restricted Reserves (includes Reports L3.1 Secondary Reserve Requirement Based on Enrollment Data, L3.2 Secondary Reserve Requirement Based on Historical Expenses, and L3.3 Adjusted and Unadjusted Medical Loss Ratio: Net Worth Requirement);

**(4)** Report L4: Key Financial Indicators;

**(5)** Report L5: Quarterly Balance Sheet of Corporate Activity Corporate Total;

**(6)** Report L6: Quarterly Statement of Revenue, Expenses and Changes in Net Assets Corporate Total and OHP Line of Business (includes Reports L6.1 Quarterly Statement of Administrative and Other Non-Benefit Costs). CCO expenditures related to sub-capitated arrangements shall be recorded in natural expense categories based on underlying costs of services;

**(7)** Report L7: Cash Flow Analysis Corporate Activity/Indirect Method Corporate Total; and

**(8)** Report L8: Corporate Relationships of Contractors

**c.** OHA will, via the DCO Contract Forms Website, supply Contractor with an Excel workbook containing the Quarterly Financial Reports. Contractor shall submit the Quarterly Financial Reports to OHA using the Excel workbook supplied by OHA. Contractor shall submit the Quarterly Financial Reports to OHA through OHA's secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.

**d.** Contractor shall submit Quarterly Financial Reports for the 1st, 2nd, and 3rd quarters to OHA two calendar months after the end of each calendar quarter. Contractor's obligation to submit its Quarterly Financial Report for the fourth quarter shall survive termination or expiration of this Contract. All Quarterly Financial Report shall be submitted to OHA as follows:

| **End of Quarter** | **Due Date of Report** |
|---|---|
| March 31, 2022 | May 31, 2022 |
| June 30, 2022 | August 31, 2022 |
| September 30, 2022 | November 30, 2022 |
| December 31, 2022 | April 30, 2023 |

**e.** Contractor shall use U.S. GAAP to define the information requested.

**f.** Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest submitted Quarterly Financial Reports. If the material change in circumstances requires restatement of prior Quarterly Financial Reports, Contractor shall amend the Quarterly Financial Reports and submit to OHA through OHA's secure file transfer protocol (SFTP) site, or other report delivery mechanism as specified by OHA, within fifteen (15) days of the date the material change is identified.

**g.** Reports annotated as an annual requirement only will include all data from the prior calendar year and are due on the dates specified on the reports.

**4. Annual Reporting Requirements**

**a.** In addition to the quarterly reports described in Section 3, Contractor shall submit annually the Audited Financial Statements as described in Section 2. If necessary, Contractor shall complete:

**(1)** Report L9: Audited Annual Balance Sheet of Corporate Activity Report;

**(2)** Report L10: Audited Annual Statement of Revenues, Expenses & Changes in Net Assets;

**(3)** These reports will provide an explanation of how the Audited Financial Statements described in Section 2 above reconcile to Reports L5 and L6. Reports L9 and L10 shall be submitted to OHA through OHA's SFTP site, or other report delivery mechanism as specified by OHA, with the Audited Financial Statements under the timeframe described in Section 2 above

**b.** Contractor shall complete Report L11: Disclosure of Compensation yearly to be uploaded with the 4th quarter submission of the Financial Reports.

**c.** Contractor shall complete Reports L12- L19 inclusive for use in the rate setting process to be uploaded with the 4th quarter submission of the Financial Reports.

**5. Assumption of Risk/Private Market Reinsurance**

**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.

**b.** Contractor shall submit Report L2 Part I, along with the Quarterly Financial Reports, due May 31st , August 31st, November 30th and April 30th. Contractor shall report Members approaching or surpassing the deductible amount of stop-loss or reinsurance. Report L2 contains instructions necessary to complete the form.

**c.** Within thirty (30) days of signing this Contract, and thereafter at the time of filing the first Quarterly Financial Report on May 31st, Contractor shall report to OHA on Report L2, Part II, the deductible amounts and the amount and associated type of stop-loss or reinsurance coverage (e.g., aggregate coverage), and the dollar amount or percentage of claim amount whereby responsibility for covering the claim reverts back to the Contractor from the re-insurer.

**6. Restricted Reserve Requirement**

**a.** Contractor, unless exempt, shall establish: (i) Restricted Reserve Account and (ii) maintain adequate funds in this account to meet OHA's Primary and Secondary Restricted Reserve requirements. Reserve funds are held for the purpose of making payments to Providers in the event of the Contractor's insolvency and assuring Contractor's performance in the event of termination of the Contract. The reserves discussed within this Contract cover only Capitated Services provided by Contractor notwithstanding Restricted Reserve amounts required to be maintained pursuant to separate contracts with the DHS or OHA.

**b.** Restricted Reserve Account: Contractor shall establish a Restricted Reserve Account with a third party financial institution for the purpose of holding Contractor's Primary and Secondary Restricted Reserve Funds. Contractors shall use the Model Depository Agreement to establish a Restricted Reserve Account.

**(1)** Model Depository Agreement shall be used by the Contractor to establish a Restricted Reserve Account. Contractor shall request the Model Depository Agreement form from

OHA. Contractor shall submit the Model Depository Agreement to OHA at the time of application and the Model Depository Agreement shall remain in effect throughout the period of time that this Contract is in effect. The Model Depository Agreement cannot be changed without OHA's written authorization.

**(2)** Withdrawal of Funds from a Restricted Reserve Account: The Contractor shall not withdraw funds, change third party financial institutions, or change account numbers within the Restricted Reserve Account without the written consent of OHA.

**(3)** Filing requirements: Contractor shall submit a copy of the Model Depository Agreement at the time of application. If Contractor requests and receives written authorization from the OHA to make a change to their existing Restricted Reserve Account, Contractor shall submit a Model Depository Agreement reflecting the changes to OHA within fifteen (15) days of the date of the change.

**(4)** Eligible Deposits: The following instruments are considered eligible deposits for the purposes of OHA's Primary and Secondary Restricted Reserves:

**(a)** Cash;

**(b)** Certificates of Deposit Certificates of Deposit;

**(c)** Amply secured obligations of the United States, a state or a political subdivision thereof as determined by OHA; or

**(d)** A Surety Bond provided it meets the requirements listed below:

**i.** Such a bond is prepaid at the beginning of the Contract, and at the beginning of each year thereafter, for eighteen (18) months;

**ii.** Evidence of prepayment is provided to OHA;

**iii.** The Surety Bond is purchased by a surety bond company approved by the Oregon Insurance Division;

**iv.** The Surety Bond Agreement contains a clause stating the payment of the bond will be made to the third-party entity holding the Restricted Reserve Account on behalf of the contracting company for deposit into the Restricted Reserve Account;

**v.** The Surety Bond Agreement contains a clause that no changes to the Surety Bond Agreement will occur until approved by OHA; and

**vi.** OHA approves the terms of the Surety Bond Agreement.

**c.** Primary and Secondary Restricted Reserves: Contractor's Primary and Secondary Reserve balances are determined by calculating the Average Fee-For-Service Liability for Capitated Services using either of the following methods: A) Enrollment Data, or B) Historical Expense Data. The Average Fee-For-Service Liability represents the cost of Covered Services that are offered by the Contractor to Members that would be owed to creditors in the event of the Contractor's insolvency. These are expenditures for Covered Services for which Contractor is at risk. These services may include out-of-area services, primary care services, referral services, and Hospital services.

**(1)** Determination of the cost is based on the usual and customary fee schedule of Contractor that has been developed to approximate the estimated Capitated Service Liability of the Contractor. Contractor shall deposit into the Restricted Reserve Account the amount required by Paragraphs (3) and (4) below of this Section 6.

**(2)** Average Fee-For-Service Liability based on Enrollment Data: If Contractor elects to calculate reserve balances based on Enrollment Data, Contractor shall complete Report L3 and L3.1. The Average Fee-For-Service Liability is calculated by multiplying the Average Capitation Rate times the Average Monthly Members times the Adjusted Member Services Expense Ratio, as follows:

**Step 1:** Enter the following data:

Net Premiums: Net Premiums received for each month of the calendar quarter, Exhibit C, Attachment 1, less the adjustments shown on Report L6 Lines 1(a) through 1(d). If Contractor provides services in more than one Service Area, use the capitation rate for the Service Area with the largest number of monthly Members in the third month.

Member Months: Contractor's average number of Members during the quarter.

**Step 2:** Determine the Adjusted Member Services Expense Ratio (Restricted Reserve):

Member Service Expenses subtotal (Report L6- OHP, Line 17)

Less: Sub-capitation and Alternative Payment Arrangements and Salary Payments (Report L8, Part II, Columns A and C)

Divided by: Total Operating Revenue (Report L6- OHP, Line 6)

**Step 3:** Calculate the Average Fee-For-Service Liability. The Excel spreadsheet provided by OHA (Report L3.1) will calculate the following:

Average Net Premiums

Times: Average Members Months

Times: Member Services Expense Ratio

Equals: Average Fee-For-Service Liability

**(3)** Average Fee-for-Service Liability based on Historical Expense Data: If Contractor has submitted Report L6 Quarterly Statements of Revenue, Expenses, and Changes in Net Assets under this Contract for the current quarter and the prior 3 quarters, Contractor is eligible to use the Historical Expense Data method. The Average Fee-For-Service Liability is an average of the prior four quarters Historical Expense Data. Contractor shall calculate the Average Fee-For-Service Liability using the Historical Method on Report L3.2 as follows:

**(a)** Average of: (current quarter plus 3 prior quarters) Member Service Expenses (Report L6 - OHP, Line 17)

**(b)** Average of: (current quarter plus 3 prior quarters) Sub-capitation and Alternative Payment Arrangements (Report L8. Part II, Column C); Plus: Salary Payments (Report L8, Part II, Column A)

**(c)** Subtract line 2 from line 1

**(d)** Divide line 3 by the number of months in a quarter or 3

**(4)** Determine Primary Reserve: If Contractor's Average Fee-For-Service Liability is less than or equal to $250,000, Contractor shall deposit into the Restricted Reserve Account an amount equal to the Average Fee-For-Service Liability from Report L3. This amount will

be referred to as the Contractor's Primary Reserve and Contractor shall have no Secondary Reserve, until such time as the Average Fee-For-Service Liability exceeds $250,000.

**(5)** Determine Secondary Reserve: If Contractor's Average Fee-For-Service Liability is greater than $250,000, Contractor is required to deposit into the Restricted Reserve Account funds equaling 50 percent of the difference between the Average Fee-For-Service Liability and the Primary Reserve balance of $250,000.

**7. Net Worth Requirement**

**a.** Contractor shall maintain a level of Net Worth that will provide for minimum adequate operating capital. A minimum adequate level of Net Worth is defined as an Adjusted Annual Average Corporate Premium to Net Worth ratio less than or equal to 20:1. Contractor shall maintain the Minimum Net Worth level, as determined by this Section, during the next calendar quarter.

**(1)** Minimum Net Worth level: Contractor shall calculate the Minimum Net Worth level by following the steps outlined below:

**Step 1:** Determine Average Corporate Premium:

Average of: (current quarter plus 3 prior quarters) Total Operating Revenue (Report L6 - CORP, Line 6)

**Step 2:** Determine Annual Average Corporate Premium:

Average Corporate Premium

Times: Four

**Step 3:** Determine the Adjusted Member Services Expense Ratio:

Member Service Expenses Subtotal (Report L8 - OHP, Line 18)

Less: Sub-capitation and Alternative Payment Arrangements and Salary Payments (Report L8, Part II, Columns A and C)

Divided by: Total Operating Revenue (Report L6 - OHP, Line 6). If the result is less than .2000, use .2000.

**Step 4:** Determine Adjusted Annual Average Corporate Premium:

Annual Average Corporate Premium

Times: Adjusted Member Services Expense Ratio

**Step 5:** Determine the Minimum level of Net Worth:

Adjusted Annualized Average Corporate Premium

Divided by: Twenty

**b.** Contractor is required to retain a dollar amount no less than 2 percent of Contractor's Adjusted Quarterly Corporate Premium Revenues as retained earnings each subsequent quarter until Contractor has a premium to surplus ratio that meets the 20:1 requirement.

**c.** Contractor shall immediately notify OHA of a material change in circumstance from the information contained in the latest-submitted Quarterly Financial Reports L6 and L8. If OHA determines that a Contractor's net worth ratio does not meet the required ratio level of 20:1, OHA will notify Contractor.

**8. Appeal Process**

**a.** If at any time, OHA believes that Contractor has incorrectly computed the amount of either its Primary or Secondary Restricted Reserve fund, or that Contractor does not meet the minimum Net Worth Requirement, OHA will notify Contractor in writing. In the event that OHA believes that the Primary or Secondary Restricted Reserve fund is inadequate, OHA will notify Contractor of the amount Contractor must maintain as its new Restricted Reserve fund and the basis on which such decision was made. In the event that OHA believes that the Net Worth is less than the minimum adequate level of Net Worth, OHA will notify Contractor of the dollar amount of no less that 2 percent of its Adjusted Quarterly Premium Revenue required to be retained each subsequent quarter until Contractor has an Adjusted Annual Average Corporate Premium to Net Worth ratio that meets the 20:1 requirement.

**b.** Within thirty (30) days of any notice by OHA under this Section, Contractor shall either:

**(1)** Adjust its Restricted Reserve funds to the amount specified by OHA and provide OHA with a copy of the restricted reserve statement showing the Restricted Reserve balance, and/or adjust its Net Worth to the amount specified by OHA and provide assurances to OHA that it is now maintaining that amount as its Net Worth, as applicable; or

**(2)** File an appeal in writing with the OHA Administrator stating in detail the reason for the appeal and submit detailed financial records that support the alternate amount.

**(3)** If Contractor files an appeal, OHA shall issue an appeal decision within forty-five (45) days of the Receipt of the Appeal. That decision shall be binding upon Contractor and not subject to further appeal

**c.** Contractor shall submit all information to be reported under the requirements of this Section to OHA through OHA's secure file transfer protocol (SFTP) site or other report delivery mechanism as specified by OHA.

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# Exhibit M – RESERVED

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# Exhibit N – Privacy and Security

## 1. Purpose

Contractor requires the Access described in the OHA-DHS form titled "Third Party Information System Access Request" (Form MSC 0785), which is hereby incorporated into this Ex. N by reference and available to Contractor at https://sharedsystems.dhsoha.state.or.us/forms/, to perform the Work. The terms and conditions of this Ex. N govern:

1.1. Contractor's Use of Data;

1.2. Contractor's Access to OHA's Information Assets and Systems; and

1.3. 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:

2.1. "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.

2.2. "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.

2.3. "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.

2.4. "Data" means information created, transmitted, or stored through the Network and Information Systems, including metadata, personal information, and Client Records.

2.5. "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.

2.6. "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.

2.7. "Information Asset(s)" refers to all information provided through OHA, regardless of the source, which requires measures for security and privacy. Includes Data.

2.8. "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 DHS programs.

2.9. "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.

2.10. "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

Contractor shall be required to provide the information necessary, and within the timeframe specified by OHA, for OHA to complete an updated "Third Party Information System Access Request" (Form MSC 0785) in order for Contractor's Access to be effective as of January 1, 2022. ISPO will review the request for Contractor's Access and provide Administrative Notice to Contractor's point of contact designated ("Designee") in Form MSC 0785 of its approval status.

3.1. **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.

3.2. **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

4.1. **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.

4.2. **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@dhsoha.state.or.us 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.

4.3. **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.

4.4. **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:

6.1. **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).

6.2. **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.

6.3. **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.

6.4. **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. http://nvlpubs.nist.gov/nistpubs/SpecialPublications/NIST.SP.800-53r4.pdf

**7. Security Requirements**

7.1. **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:

7.1.1. DHS and OHA Information Security and Privacy Policies: https://www.oregon.gov/oha/FOD/OIS-ISPO/Pages/Policies.aspx

7.1.2. DHS and OHA Privacy and Confidentiality administrative rules, OAR Chapter 407, Division 14, and OAR Chapter 943, Division 14.

7.1.3. Those referenced in this Ex. N or in Ex. E, "Required Federal Terms and Conditions, Sec. 6, "HIPAA Compliance".

7.1.4. The Oregon Consumer Identity Theft Protection Act, ORS 646A.600 through 646A.628, to the extent applicable.

7.1.5. Oregon's Statewide Information Security Standards: https://www.oregon.gov/das/OSCIO/Documents/2019StatewideInformationAndCyberSecurityStandardsV1.0.pdf

7.1.6. Oregon's Statewide Information Security Plan: https://www.oregon.gov/das/OSCIO/Documents/StatewideInformationSecurityPlan.pdf.

7.1.7. Oregon's Statewide Policies: https://www.oregon.gov/das/Pages/policies.aspx#IT.

7.1.8. Security controls that meet or exceed "Moderate" security controls in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53.

7.2. **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.

7.3. **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.

7.4. **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.

7.5. **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:

7.5.1. Determine Contractor's compliance with this Ex. N,

7.5.2. Validate Contractor's written security risk management plan, or

7.5.3. Gather or verify any additional information OHA may require to meet any State or federal laws, rules, or orders regarding Information Assets.

7.6. 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**

8.1. **OHA Review of User Requests.** If required for Access, OHA will review requests, including forms such as the Individual Access Request ("IAR"), and will:

8.1.1. Notify Contractor of the approval or denial of its request for each User for whom Access has been requested;

8.1.2. Provide any unique log-on identifier required for authorized Access;

8.1.3. Provide updates to approved inquiry processes and instructions to Contractor.

8.2. **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.

8.2.1. 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.

8.2.2. Contractor is responsible for ensuring information provided by its Users is accurate, complete, and up to date.

8.2.3. 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.

8.3. **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.

8.4. **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.

8.5. **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@dhsoha.state.or.us 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.

8.6. **Authorized Access and Use Only.** No User may Access or use Data for any purpose other than those specifically authorized through this Contract.

8.6.1. Users shall not use Access to obtain or attempt to obtain any Data or Information Assets not authorized or intentionally made available.

8.6.2. 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.

8.6.3. Except as otherwise specified or approved by OHA, neither Contractor nor its Users may modify, alter, delete, or destroy any Information Asset.

8.7. **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.

8.8. **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.

8.9. **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.

8.10. **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.

8.11. **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[26]

9.1. Contractor's breach of this Ex. N may result in one or more Sanctions identified in OAR 410-141-3530. 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

[26] OHA expects to propose administrative rules that may supersede this contract language to the extent of any inconsistency.

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.

9.2. 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.

9.3. 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.

Exhibit C – Attachment 1

**DCO Payment Rates**

Exhibit D – Attachment 1

# Deliverables and Required Notices