

## Appendix A - Definitions

For purposes of this RFA (including its Attachments and Appendices) and the resulting Contract, the terms below shall have the following meanings when capitalized. If a term defined below is used without capitalization in this RFA, then the context determines whether the term is intended to be used with the defined meaning.

### A. Terms defined in OAR 309-019-0105

Acute Care Psychiatric Hospital	Peer Wellness Specialist
Assertive Community Treatment (ACT)	Psychiatrist
Family Support	Psychologist
Local Mental Health Authority (LMHA)	Qualified Mental Health Associate (QMHA)
Mobile Crisis Services	Qualified Mental Health Professional (QMHP)
Peer	
Peer-Delivered Services (PDS)	
Peer Support Specialist	

### B. Terms defined in OAR 309-032-0311

Individual Service and Support Plan (ISSP)

### C. Terms defined in OAR 410-120-0000

Acute	Dental Services
Adverse Benefit Determination	Dentist
Adverse Event	Department of Human Services (Department)
Aging and People with Disabilities (APD)	Diagnosis Related Group (DRG)
Allied Agency	Diagnostic Services
Ambulance	Division
Ambulatory Surgical Center (ASC)	Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
American Indian/Alaska Native (AI/AN)	Emergency Department
American Indian/Alaska Native (AI/AN) Clinic	Emergency Medical Condition
Ancillary Services	Emergency Medical Transportation
Area Agency on Aging (AAA)	Emergency Services
Automated Voice Response (AVR)	False Claim
Benefit Package	Family Planning Services
Behavioral Health	Federally Qualified Health Center (FQHC)
Case Management Services	Fee-for-Service Provider
Child Welfare (CW)	Fully Dual Eligible
Children's Health Insurance Program (CHIP)	Healthcare Common Procedure Coding System (HCPCS)
Citizen/Alien-Waived Emergency Medical (CAWEM)	Health Evidence Review Commission
Claimant	Health Insurance Portability and Accountability Act (HIPAA)
Client	Hospice
Clinical Record	Hospital
Community Mental Health Program (CMHP)	Indian Health Care Provider (IHCP)
Contested Case Hearing	Indian Health Service (IHS)
Co-Payments	Inpatient Hospital Services
Cost Effective	Laboratory
Covered Services	Laboratory Services
Date of Receipt of a Claim	Liability Insurance
Date of Service	
Declaration for Mental Health Treatment	

Managed Care Organization (MCO)  
Medicaid  
Medical Assistance Program  
Medical Services  
Medically Appropriate  
Medicare  
Medicare Advantage  
National Correct Coding Initiative (NCCI)  
Non-Covered Services  
Non-Emergent Medical Transportation Services (NEMT)  
Nurse Practitioner  
Nursing Facility  
Oregon Health Authority (Authority)  
Oregon Youth Authority (OYA)  
Overpayment  
Pharmaceutical Services  
Physician  
Physician Assistant  
Practitioner  
Prepaid Health Plan (PHP)  
Primary Care Provider (PCP)  
Prior Authorization (PA)  
Prioritized List of Health Services  
Provider  
Provider Organization  
Qualified Medicare Beneficiary (QMB)

Quality Improvement  
Recipient  
Recoupment  
Referral  
Remittance Advice (RA)  
Request for Hearing  
Rural  
Sanction  
School Based Health Service  
State Facility  
Subrogation  
Supplemental Security Income (SSI)  
Surgical Assistant  
Suspension  
Termination  
Third Party Liability (TPL), Third Party Resource (TPR) or Third Party Payer  
Transportation  
Type A Hospital  
Type B AAA  
Type B Hospital  
Urban  
Urgent Care Services  
Usual Charge (UC)  
Utilization Review (UR)

**D. Terms Defined in OAR 410-141-3000**

Applicant  
Application  
Benefit Period  
Business Day  
CCO Payment  
Cold Call Marketing  
Community Advisory Council (CAC)  
Community Standard  
Coordinated Care Organization (CCO)  
Coordinated Care Services  
Corrective Action or Corrective Action Plan  
Dental Care Organization (DCO)  
Department of Consumer and Business Services (DCBS)  
Disenrollment

Enrollment  
Exceptional Needs Care Coordination (ENCC)  
Global Budget  
Grievance System  
Health-Related Services (HRS)  
Holistic Care  
Licensed Health Entity  
Marketing  
Mental Health Organization (MHO)  
Non-Participating Provider  
Participating Provider  
Potential Member  
Request for Applications (RFA)  
Service Area  
Treatment Plan

**E. Terms defined in OAR 410-141-3270**

Marketing Materials  
Outreach  
Outreach Materials

**F. Terms Defined in ORS 414.018**

Community  
Region

**G. Terms Defined in ORS 414.025**

Alternative Payment Methodology  
Community Health Worker  
Personal Health Navigator  
Quality Measure

**H. Terms Defined by this RFA**

1. **“340B Drug”** means a drug purchased at the prices authorized under Section 340B of the Public Health Service Act.
2. **“340B Entity”** means a federally designated Community health center or other federally qualified covered entity that is listed on the Health Resources and Services Administration (HRSA) website.
3. **“340B Ceiling Price”** means the maximum statutory price established under section 340B(a)(1) of the Public Health Services Act.
4. **“AP Standard”** means the standard for accurate and timely submission of all Valid Claims for a Subject Month within 45 days of the date of adjudication and the correction of Encounter Data requiring correction with 63 days of the date of notification, applying the standard in OAR 410-141-3430 in effect for the Subject Month.
5. **“Abuse”** means improper behaviors or billing practices including, but not limited to:
  - Billing for a non-covered service;
  - Misusing codes on the claim (i.e., coding that does not comply with national or local coding guidelines or is not billed as rendered); or
  - Inappropriately allocating costs on a cost report
6. **“Actuarial Report”** is defined in the Sample Contract, Exhibit C, Section 7
7. **“Acute Inpatient Hospital Psychiatric Care”** means Acute care provided in an Acute Care Psychiatric Hospital.
8. **“Administrative Performance Penalty”** (or AP Penalty or APP) means the dollar amount equal to one percent (1%) of the Contractor’s adjusted Capitation Payment paid for the Subject Month (including monthly and weekly payments combined for the Subject Month) as described in Exhibit C, Section 11 that will be withheld during the Withhold Month.
9. **“Advance Directive”** means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated pursuant to 42 CFR 438.3(j); 42 CFR 422.128; and 42 CFR 489.100. A “health care instruction” means a document executed by a principal to indicate the principal’s instructions regarding health care decisions. A “power of attorney for health care” means a power of attorney

document that authorizes an attorney-in-fact to make health care decisions for the principal when the principal is incapable. “Incapable” means that in the opinion of the court in a proceeding to appoint or confirm authority of a health care representative, or in the opinion of the principal’s attending Physician, a principal lacks the ability to make and communicate health care decisions to health care Providers, including communication through persons familiar with the principal’s manner of communicating if those persons are available.

10. **“Affiliate”** of, or person **“Affiliated”** with, a specified person 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.
11. **“Appeal”** means a request for review of a notice of action/Adverse Benefit Determination.
12. **“Assessment”** means the determination of a person's need for Covered Services. It involves the collection and evaluation of data pertinent to the person's history and current problem(s) obtained through interview, observation, and record review.
13. **“Assignment”** means the process by which a Client is deemed eligible to be assigned to Contractor, either in a manual or automated process.
14. **“Automatic Re-enrollment”** means a re-enrollment of a Member with the Contractor when the Client was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
15. **“Baseline”** for each Incentive Measure means Contractor’s Baseline measurement for the Incentive Measure for the Baseline Year.
16. **“Baseline Year”** means the calendar year for which the Incentive Measures for a Measurement Year are compared.
17. **“Behavioral Health Only (BHO) Emergency Services”** means health services from a qualified Provider necessary to evaluate or stabilize an emergency Behavioral Health condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a Member’s discharge from a facility or transfer to another facility.
18. **“Behavioral Health Only (BHO) Member”** means an individual enrolled for BHO Covered Services only. An BHO Member is an individual who receives physical health services on a fee-for-service basis but who is eligible for and is enrolled in a CCO for BHO Covered Services only (i.e. CCO-E/G).
19. **“Behavioral Health Only (BHO) Covered Service”** means those Behavioral Health services that are included in the CCO Payment paid to Contractor under the Contract with respect to an BHO Member whenever those Behavioral Health services are Medically Appropriate for the BHO Member (i.e. CCO-E/G).
20. **“Benchmark”** for each Incentive Measure means the statewide benchmark published at <http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx> for the Incentive Measure for the Measurement Year, subject to change by the Metrics and Scoring Committee.
21. **“Capitation Payment”** means the portion of the CCO Payment paid under the Capitation Rates (as described in Sample Contract, Exhibit C, Section 6) and excludes case rate payments, maternity case rate, withholds, or any other payments paid outside the Capitation Rate.
22. **“CCO Administrative Rules”** means OHA’s rules governing CCOs at OAR 410-141-3000 to 410-141-4120.

23. **“CCO Payment Rates”** means the rates for CCO Payments to Contractor as set forth in Sample Contract, Exhibit C, Attachment 1.
24. **“CCO Risk Corridor”** means a risk sharing mechanism in which OHA and Contractor share in both higher and lower than adjusted expenses under the Contract outside of the predetermined target amount, so that if Contractor’s adjusted expenses are outside the corridor in which the Contractor is responsible for all its adjusted expenses, the OHA contributes a portion toward additional adjusted expenses, or receives a portion of lower adjusted expenses.
25. **“Care Coordinator”** is a single, consistent individual who: is familiar with a Member’s history, strengths, needs and support system; follows a Member through transitions in levels of care, Providers, involved systems and legal status; takes a system-wide view to ensure services are unduplicated and consistent with identified strengths and needs; and who fulfills Care Coordination standards as identified in this Contract.
26. **“Care Coordination”** is a series of actions contributing to a patient-centered, high-value, high-quality care system. Care Coordination is defined as the organized coordination of Member’s health care services and support activities between two or more participants deemed responsible for the Member’s health outcomes and minimally includes the Member (and their family/caregiver as appropriate) and a single consistent individual in the role of care coordinator. Organizing the delivery of care and resources involves a team-based approach focused on the needs and strengths of the individual Member. The Care Coordinator insures that participants involved in a Member’s care facilitate the appropriate delivery of health care services and supports. Successful Care Coordination requires the exchange of information among participants responsible for meeting the needs of the Member, explicit assignments for the functions of specific staff members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes. Successful Care Coordination is achieved when the health care team, including the Member and Family/caregiver, supported by the integration of all necessary information and resources, chooses and implements the most appropriate course of action at any point in the continuum of care to achieve optimal outcomes for Members.
27. **“Charge”** means the flow of funds from the Contractor to the OHA.
28. **“Child and Family Team”** means a group of people, chosen by the Family and connected to them through natural, Community, and formal support relationships, and representatives of child-serving agencies who are serving the child and Family, who will work together to develop and implement the Family’s plan, address unmet needs, and work toward the Family’s vision.
29. **“Choice Area”** means a Membership Service Area with more than one Contractor, if any of the Contractors does not hold a CCO contract with OHA for the 2019 Contract Year.
30. **“Civil Commitment”** means the legal process of involuntarily placing a person, determined by the Circuit Court to be a person with a mental illness as defined in ORS 426.005 (1) (f), in the custody of OHA. OHA has the sole authority to assign and place a committed person to a treatment facility. OHA has delegated this responsibility to the CMHP Director.
31. **“Claims Adjudication”** means Contractor’s final decision to pay claims submitted or deny them after comparing claims to the benefit or coverage requirements.
32. **“Clinical Reviewer”** means the entity individually chosen to resolve disagreements related to a Member's need for LTPC immediately following an Acute Inpatient Hospital Psychiatric Care stay.
33. **“Contract”** means a Contract awarded as a result of this RFA.

34. **“Contractor”** means an Applicant selected through this RFA to enter into a Contract with OHA to perform the Work.
35. **“Control,”** including its use in the terms “controlling,” “controlled,” “controlled by” and “under common control with,” means possessing the direct or indirect power to manage a person or set the person’s policies, whether by owning voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position or corporate office the person holds.
36. **“Cultural Competence”** means the same as “Cultural Awareness” as defined in OAR 309-019-0105. Operationally defined, Cultural Competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.
37. **“Culturally Responsive”** means the capacity to respond to the issues of diverse communities and requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.
38. **“DSM-5 Diagnosis”** means the diagnosis, consistent with the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), resulting from the clinical Assessment of a Member.
39. **“DATA Waived”** means Authorization from the U.S. Drug Enforcement Administration wherein physicians are qualified as practitioners (DATA Waived Provider (DWP)) pursuant to DATA (The Drug Addiction Treatment Act of 2000) and will be authorized to conduct maintenance and detoxification treatment using specifically approved schedule III narcotic medications.
40. **“Distribution Year”** means the calendar year following the Measurement Year.
41. **“Dyadic Treatment”** means a developmentally appropriate, evidence supported therapeutic intervention which is designed to actively engage one caregiver and one child together during the intervention to reduce symptomology in one or both participants, and to improve the caregiver-child relationship.
42. **“Early Intervention”** means the provision of Covered Services directed at preventing or ameliorating a mental disorder or potential disorder during the earliest stages of onset or prior to onset for individuals at high risk of a mental disorder.
43. **“Effective Date”** means the date the Contract becomes effective, as described in Section I.A of the Contract.
44. **“Electronic Health Record”** means an electronic record of an individual’s health-related information that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff.
45. **“Emergency Dental Condition”** has the meaning defined in OAR 410-120-0000(69)
46. **“Emergency Psychiatric Hold”** means the physical retention of a person taken into custody by a peace officer, health care facility, State Facility, Hospital or nonhospital facility as ordered by a Physician or a CMHP director, pursuant to ORS Chapter 426.
47. **“Encounter Data”** means encounter claims data that are required to be submitted to OHA under OAR 410-141-3430.
48. **“Encounter Pharmacy Data”** means encounter claims data for Pharmaceutical Services delivered by organizations authorized to provide Pharmaceutical Services under OAR 410-121-

0021 and billed through the National Council for Prescription Drug Programs (NCPDP) standard format utilizing the National Drug Code (NDC) and following the billing requirements in OAR 410-121-0150.

49. **“Episode of Care”** means care that begins at treatment admission and ends at discharge. An admission has occurred if, and only if, the Client begins treatment. Events such as initial screening, Referral, and wait-listing for treatment are considered to take place before the admission to treatment and should not be considered as admission.
50. **“Evidence-Based”** means well-defined practices that are based directly on scientific evidence and that have been demonstrated to be effective through research studies.
51. **“Expiration Date”** means December 31<sup>st</sup> of each calendar year during the term of the Contract.
52. **“External Quality Review Organization” or “EQRO”** means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358 or both.
53. **“External Quality Review” or “EQR”** means the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that Contractor furnishes to its Members, and other EQR-related activities as set forth in 42 CFR 438.358.
54. **“Family Partner”** has the same meaning as Family Support Specialist as defined OAR 410-180-0305(13)(d),
55. **“Family”** means parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship.
56. **“Fidelity”** means the extent to which a program adheres to the evidence-based practice model. Fidelity to the Wraparound model means that an organization participates in measuring whether Wraparound is being implemented to Fidelity, and will require, at a minimum, assessing (1) adherence to the core values and principles of Wraparound described in ORS 418.977, (2) whether the basic activities of facilitating a Wraparound process are occurring, and (3) supports at the organizational and system level.
57. **“Final Submission Month”** means six months after the last day of the Subject Month.
58. **“Fraud”** means the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes knowing the deception could result in some unauthorized benefit to himself or some other person(s).
59. **“Governance Structure” or “Governing Board”** means the Board of Directors or Board of Trustees of a corporation, or the comparable governing body for any other form of Legal Entity.
60. **“Grievance”** means a Member's or Member Representative's expression of dissatisfaction to Contractor or to a Participating Provider about any matter other than an Adverse Benefit Determination.
61. **“Habilitation Services”** means the services set forth in OAR 410-172-0700.
62. **“Health Care-Acquired Condition”** has the meaning defined in 42 CFR 447.26(b).
63. **“Health Information Exchange (HIE)”** means the electronic movement of health information among disparate organizations and health information systems.

64. **“Homeless”** means an individual with no fixed residential address, including individuals in shelters, are unsheltered, or who are doubled up and staying temporarily with friends or family.” For more information on this definition, please refer to <https://www.nhchc.org/faq/official-definition-homelessness/>
65. **“Improvement Target”** for an Incentive Measure means the amount (determined by the methodology set forth in the Reference Instructions and Improvement Targets document online at <http://www.oregon.gov/oha/analytics/pages/cco-baseline-data.aspx> by which Contractor’s performance on each Incentive Measure is to improve during the Measurement Year by comparison with the Baseline.
66. **“Incentive Measures”** means the Quality Measures specified by OHA for a Measurement Year, subject to change by the Metrics and Scoring Committee and CMS approval.
67. **“Initial Procurement Expense”** means expenses for physical, behavioral, dental and NEMT services including prescription drugs except for Hepatitis C DAA Drugs.
68. **“Initial Procurement Risk Corridor Period”** means January 1, 2020 through June 30, 2020.
69. **“Initial Procurement Risk Corridor Revenue”** means capitation rates for Medical Services less the amount for Hepatitis C DAA Drugs specified in the Contract Rates as set forth in Attachment 1 to this Exhibit C multiplied by Contractor’s Member Enrollment for the General Risk Corridor time period. **“Innovator Agent”** means an OHA employee who is assigned to a CCO and serves as a single point of contact between a CCO and the OHA to facilitate the exchange of information between the CCO and the OHA.
70. **“Intensive Care Coordinator” (ICC)** has the meaning as defined in OAR 410-141-3170.
71. **“Intensive Care Coordination Plan” (ICCP)** means a collaborative, comprehensive, integrated and interdisciplinary-focused written documentation that includes details of the supports, desired outcomes, activities, and resources required for an individual receiving ICC services to achieve and maintain personal goals, health, and safety. It identifies explicit assignments for the functions of specific care team members, and addresses interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal health and wellness outcomes.
72. **“Intensive Outpatient Services and Supports”** means a specialized set of comprehensive in-home and Community-based supports and mental health treatment services, for children and youth, that are developed by the Child and Family Team and delivered in the most integrated setting in the Community.
73. **“Intensive Psychiatric Rehabilitation”** means the application of concentrated and exhaustive treatment for the purpose of restoring a person to a former state of mental functioning.
74. **“Intensive Treatment Services (ITS)”** means the range of services delivered within a facility and comprised of Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS), Subacute and other services as determined by OHA, that provide active psychiatric treatment for children with severe emotional disorders and their families.
75. **“Invoiced Rebate Dispute”** means a disagreement between a pharmaceutical manufacturer and the Contractor regarding the dispensing of pharmaceuticals, as submitted by OHA to Contractor through the process set forth in Sample Contract, Exhibit B, Part 8, Section 12.
76. **“Hepatitis C DAA Drugs”** means the class of direct acting antiviral (DAA) drugs to treat Hepatitis C.
77. **“Hepatitis C DAA Expense”** means encounters with a paid amount recorded for Hepatitis C DAA drugs during the Hepatitis C Risk Corridor Period.

78. **“Hepatitis C DAA Revenue”** means an amount included in the Hepatitis C DAA adjustment specified in the Contractor Rates as set forth in Attachment 1 to this Exhibit C multiplied by Contractor’s Member Enrollment for the Hepatitis C Risk Corridor Period.
79. **“Hepatitis C DAA Admin Revenue”** means the administrative allowance attributed to the Hepatitis C DAA adjustment in Attachment 1 to this Exhibit C multiplied by Contractor’s Member Enrollment for the Hepatitis C Risk Corridor Period.
80. **“Hepatitis C Risk Corridor Period”** means January 1, 2020 through December 31, 2020.
81. **“Housing-Related Services and Supports”** means the services and supports that help people find and maintain stable and safe housing. Services and supports may include services at the individual level (e.g. individual assistance with a housing application process), or at the community level (e.g. community health workers stationed in affordable housing communities).
82. **“Learning Collaborative”** means a program in which CCOs, state agencies, and PCPCHs can do the following, as well as other activities that serve Health System Transformation objectives and the purposes of the Contract:
- a. Share information about Quality Improvement;
  - b. Share information and best practices about methods to change payment to pay for quality and performance;
  - c. Share best practices and emerging practices that increase access to Culturally Responsive and linguistically appropriate care and reduce health disparities;
  - d. Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care;
  - e. Coordinate efforts to develop and test methods to align financial incentives to support PCPCHs;
  - f. Share best practices for maximizing the utilization of PCPCHs by individuals enrolled in Medical Assistance Programs, including culturally specific and targeted Outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;
  - g. Share best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services;
  - h. Share information and best practices on the use of Health-Related Services; and
  - i. Share information and best practices on Member engagement, education and communication.
83. **“Licensed Medical Practitioner (LMP)”** means a person who meets the following minimum qualifications as documented by the Local Mental Health Authority (LMHA) or designee:
- a. Physician, Nurse Practitioner, or Physician's Assistant, who is licensed to practice in the State of Oregon, and whose training, experience and competence demonstrate the ability to conduct a Mental Health Assessment and provide medication management; or
  - b. For Intensive Outpatient Services and Support (IOSS) and Intensive Treatment Services (ITS) Providers, a board-certified or board-eligible child and adolescent Psychiatrist licensed to practice in the State of Oregon per OAR 309-019-0105.

84. **“Long-Term Psychiatric Care” or “LTPC”** means inpatient psychiatric services delivered in an Oregon State-operated Hospital after Usual and Customary care has been provided in an Acute Inpatient Hospital Psychiatric Care setting or in a Residential Treatment Facility for children under age 18 and the individual continues to require a Hospital level of care.
85. **“MAT”** means Medication Assisted Treatment
86. **“MMLR Rebate Period”** means a cumulative rolling three-year Reporting Period for the MMLR Rebate Report. The initial Rebate Period shall be for Reporting Periods 2020-2022.
87. **“MMLR Rebate Report”** means Contractor’s report of financial information required for calculating MMLR.
88. **“MMLR Rebate”** means the dollar amount which, if added to Contractor’s Total Incurred Medical Related Costs for the Rebate Period, would result in an MMLR equal to the MMLR Standard. If Contractor’s MMLR for the Rebate Period exceeds the MMLR Standard, the Rebate is zero.
89. **“MMLR Standard”** means an MMLR exceeding 85% for the Contractor’s total Member population.
90. **“Measurement Year”** means the preceding calendar year.
91. **“Medication Override Procedure”** means the administration of psychotropic medications to a person in an Acute Inpatient Hospital Psychiatric Care setting when the person has refused to consent to the administration of such medications on a voluntary basis.
92. **“Member Months”** means Contractor’s average number of Members during a quarter, multiplied by the number of months.
93. **“Member Representative”** means a person who can make OHP related decisions for a Member who lacks the ability to make and communicate health care decisions to health care Providers, including communication through persons familiar with the principal’s manner of communicating if those persons are available. A Member Representative may be, in the following order of priority, a person who is designated as the Member’s health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other Family member as designated by the Member, the Individual Service Plan Team (for Members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a DHS or OHA case manager or other DHS or OHA designee. For Members in the care or custody of DHS Children, Adults, and Families (CAF) or OYA, the Member Representative is DHS or OYA. For Members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the Member Representative is his or her parent or legal guardian.
94. **“Member”** means a Client who is enrolled with Contractor under the Contract. For all purposes in the Contract, apart from the requirements for provision of Covered Services that are limited to Behavioral Health Covered Services, a BHO Member is a Member of the CCO.

- 95. “Membership Service Area”** means:
- a. For a county in which OHA did not award any Contractor a Service Area of less than all of the county: the whole county; and
  - b. For a county in which OHA did award any Contractor a Service Area of less than all of the county: the part of county awarded as the Service Area, and separately the part of the county not awarded as the Service Area.
- 96. “Mental Health Practitioner”** means a person with current and appropriate licensure, certification, or accreditation in a mental health profession, which includes but is not limited to: Psychiatrists, Psychologists, registered psychiatric nurses, QMHAs, and QMHPs.
- 97. “Mental Health Rehabilitative Services”** means coordinated Assessment, therapy, consultation, medication management, skills training and interpretive services.
- 98. “Metrics and Scoring Committee”** means the subcommittee established in accordance with ORS 414.638(1).
- 99. “NAIC”** means National Association of Insurance Commissioners
- 100. “Neuropsychiatric Treatment Service” or “NTS”** means four units at the State Facility serving frail elderly persons with mental disorders, head trauma, advanced dementia, or concurrent medical conditions who cannot be served in Community programs.
- 101. “Non-Pharmacy Encounter Data”** means institutional and Dental encounter claims that are required to be submitted to OHA under OAR 410-141-3430 and OAR 943-120-0100 through 943-120-0200.
- 102. “OEBB”** means the Oregon Educators Benefit Board within OHA.
- 103. “Office of Contracts and Procurement” (OC&P)** means the office that is responsible for the procurement and contracting process for OHA.
- 104. “OHP”** means Oregon Health Plan.
- 105. “OHPB”** means the Oregon Health Policy Board.
- 106. “Offsets”** means amounts that are not included in the CCO Payment from OHA but that are received from other sources in relation to allowable expenses covered by this Risk Corridor. Offsets include but are not limited to Third Party Resources, Medicare, reinsurance (if any), or other funds or services that resulted in reduction of expenses. Offsets are calculated on an accrual basis.
- 107. “Open Enrollment”** means a period where Members who reside in a Choice Area may make changes to their CCO Enrollment.
- 108. “Oregon Integrated and Coordinated Health Care Delivery System”** means the system that makes CCOs accountable for care management and provision of integrated and coordinated health care for each Member, managed within fixed Global Budgets, by providing care so that efficiency and Quality Improvements reduce medical cost inflation while supporting the development of regional and Community accountability for the health of the residents of each Region and Community, and while maintaining regulatory controls necessary to ensure quality and affordable health care for all Oregonians.
- 109. “Oregon Patient/Resident Care System” or “OP/RCS”** means the OHA data system for persons receiving services in the State Facilities and selected Community Hospitals providing Acute Inpatient Hospital Psychiatric services under contract with OHA.
- 110. “OSH”** means Oregon State Hospital.

- 111. “Patient Protection and Affordable Care Act” or “PPACA”** means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) as modified by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
- 112. “Patient-Centered Primary Care Home” or “PCPCH”** means a health care team or clinic as defined in ORS 414.025(19), which meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
- 113. “Payment”** means the flow of funds from OHA to Contractor
- 114. “PEBB”** means the Public Employees Benefit Board within OHA.
- 115. “Personal Care Services”** means services that must be prescribed by a Physician or licensed Practitioner of the healing arts in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State or designee. The services are provided by an individual who is qualified to provide such services and who is not a legally responsible relative of the Individual. The services may be furnished in a home or other allowable location. The services meeting this criterion are listed in OAR 410-172-0780.
- 116. “Post Stabilization Services”** means Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member’s condition when the Contractor does not respond to a request for pre-approval within one hour, the Contractor cannot be contacted, or the Contractor’s representative and the treating Physician cannot reach an agreement concerning the Member’s care and a Contractor Physician is not available for consultation
- 117. “Previous Contract”** means Contractor’s contract with OHA for Coordinated Care Services that expired immediately before the Effective Date of the Contract.
- 118. “Prioritized Populations”** means individuals with SPMI, children 0-5 at risk of maltreatment, children showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis, individuals in medication assisted treatment for SUD, pregnant women and parents with dependent children, children with neonatal abstinence syndrome, children in Child Welfare, IV drug users, individuals with SUD in need of withdrawal management, individuals with HIV/AIDS, individuals with tuberculosis, Veterans and their families, individuals at risk of First Episode Psychosis, and individuals within the I/DD population, and other prioritized members.
- 119. “Provider Panel” or “Provider Network”** means those Participating Providers Affiliated with the Contractor who are authorized to provide services to Members.
- 120. “Provider-Preventable Condition”** has the meaning defined in 42 CFR 447.26(b).
- 121. “Psychiatric Day Treatment Services (PDTs)”** means the comprehensive, interdisciplinary, non-residential, Community-based program consisting of psychiatric treatment, Family treatment and therapeutic activities integrated with an accredited education program.
- 122. “Psychiatric Residential Treatment Service” or “PRTS”** has the meaning defined in OAR 410-172-0010.
- 123. “Quality Pool”** means dollar amounts that OHA will pay CCOs as incentives for performance on Incentive Measures specified in the Exhibit C.
- 124. “Race, ethnicity, preferred spoken and written languages and disability status standards” or “REAL-D standards”** means standards under ORS 413.161.
- 125. “Readiness Review”** means a determination by OHA that an Applicant or CCO is qualified to hold a CCO Contract.

126. **“Receiving CCO”** means the CCO that is receiving Members during the Open Enrollment period who were previously enrolled with another CCO in 2019.
127. **“Renew”** means an agreement by OHA and Contractor to amend the terms or conditions of the Contract for the next Benefit Period. “Renew” does not include expiration of the Contract followed by a successor contract.
128. **“Renewal Contract”** means either: (1) a Rate Amendment described in Sample Contract, Exhibit C, Section 11; or (2) an amendment extending this term of the Contract.
129. **“SRTF”** means Secure Residential Treatment Facility.
130. **“Serious and Persistent Mental Illness”** (SPMI) has the meaning defined in OAR 309-036-0105.
131. **“Services Coordination”** means Services provided to Members who require access to and receive Covered Services, or long term care services, or from one or more Allied Agencies or program components according to the Treatment Plan. Services provided may include establishing pre-commitment service linkages; advocating for treatment needs; and providing assistance in obtaining entitlements based on mental or emotional disability.
132. **“Social Determinants of Health and Health Equity”** or **“SDOH-HE”** SDOH means the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social determinants of health include, but are not limited to: Poverty, education, employment, food insecurity, diaper insecurity, housing, access to quality child care, environmental conditions, trauma/adverse childhood experiences, and transportation. SDOHE means the Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. Institutional racism is one example. Together SDOH-HE is the combined factors of the social determinants of health and the social determinants of health equity.
133. **“Special Health Care Needs”** means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either 1) have functional disabilities, 2) live with health or social conditions that place them at risk of developing functional disabilities (for example, serious chronic illnesses, or certain environmental risk factors such as homelessness or Family problems that lead to the need for placement in foster care), or 3) are a Member of the Prioritized Populations listed in the Contract.
134. **“State”** means the State of Oregon.
135. **“Statewide Supplemental Rebate Agreement”** means an agreement entered into by OHA with a prescription drug manufacturer for a pricing agreement /or rebate agreement, or combination thereof, with requirements regarding dispensing criteria, preferred drug list placement, or Prior Authorization criteria. OHA will provide Contractor a list of the provisions applicable to Contractor as contained within the Statewide Supplemental Rebate Agreement to ensure consistent application of the provisions contained therein by all CCOs. OHA will provide Contractor 60 days’ prior written notice of the applicable Statewide Supplemental Rebate Agreement provisions.
136. **“Subcontractor”** means any individual, entity, facility, or organization, other than a Participating Provider, that has entered into a subcontract with the Contractor or with any Subcontractor for any portion of the Work under the Contract.
137. **“Subject Month”** means the month in which the Date of Service occurred that is under review for timely and accurate Encounter Data submission using the AP Standard.

- 138. “Substance Use Disorders Provider”** means a Practitioner approved by OHA to provide Substance Use Disorders services.
- 139. “Substance Use Disorders” (SUDs)** means disorders related to the taking of a drug of abuse including alcohol, to the side effects of a medication, or to a toxin exposure. The disorders include Substance Use Disorders, such as substance dependence and substance abuse, and substance-induced disorders, such as substance intoxication, withdrawal, delirium, dementia, and substance-induced psychotic or mood disorder, as defined in DSM-V criteria.
- 140. “Supported Employment Services”** means the same as “Individual Placement and Support (IPS) Supported Employment Services” as defined in OAR 309-019-0225.
- 141. “Supported Housing”** is permanent housing with tenancy rights and support services that enables people to attain and maintain integrated affordable housing. Support services offered to people living in Supported Housing are flexible and are available as needed and desired, but are not mandated as a condition of obtaining tenancy. People have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Supported Housing enables individuals with disabilities to interact with individuals without disabilities to the fullest extent possible. Supported Housing is scattered site housing. To be considered Supported Housing, for buildings with two or three units, no more than one unit may be used to provide Supported Housing for people with SPMI who are referred by OHA or its contractors, and for buildings or complexes with four or more units, no more than 25% of the units in a building or complex may be used to provide Supported Housing for people with SPMI who are referred by OHA or its contractors. Supported Housing has no more than two people in a given apartment or house, with a private bedroom for each individual. If two people are living together in an apartment or house, the individuals must be able to select their own roommates. Supported Housing does not include housing where providers can reject individuals for placement due to medical needs or substance abuse history.
- 142. “System of Care” (SOC)** means a coordinated network of services and supports, including education, Child Welfare, public health, primary care, pediatric care, juvenile justice, Behavioral Health treatment, substance use treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is Culturally Responsive and linguistically competent, that is designed to build meaningful partnerships with families and youth in the delivery and management of services and the development of a supportive policy and management infrastructure.
- 143. “Team Facilitation”** means the process of working with the Child and Family Team in developing a unified plan of care.
- 144. “Traditional Health Worker” (THW)** has the meaning defined in OAR 410-180-0305.
- 145. “Trauma Informed”** means a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.
- 146. “Transferring CCO”** means the CCO that is transferring Members during the Open Enrollment period to another CCO, because of 2019 contract termination, Member choice or auto Assignment.
- 147. “Transitional Care”** means assistance for a Member when entering and leaving an Acute care facility or a long term care setting.

- 148.** “**Tribes**” means Oregon’s nine federally recognized Tribes and, as the context requires, includes Oregon’s Urban Indian Health Program.
- 149.** “**Valid Claim**” means a claim received by the Contractor for Payment of Covered and Non-covered Services rendered to a Member which: (1) Can be processed without obtaining additional information from the Provider of the service; and (2) Has been received within the time limitations prescribed in OHP Rules. A “Valid Claim” does not include a claim from a Provider who is under investigation for Fraud or Abuse, or a claim under review for being Medically Appropriate. A “Valid Claim” is a “clean claim” as defined in 42 CFR 447.45(b).
- 150.** “**Valid Encounter Data**” means Encounter Data that comply with OAR 410-141-3430.
- 151.** “**Value-Based Payment**” (VBP) mean payment to a Provider that explicitly rewards the value that can be produced through the provision of health care services to CCO Members. VBP categories include, but are not limited to:
- a. Foundational Payments for Infrastructure and Operations;
  - b. Pay for Reporting;
  - c. Rewards for Performance/Penalties for Performance;
  - d. Shared savings;
  - e. Shared risk;
  - f. Partial Capitation or Episode-based Payments;
  - g. Comprehensive Population-based Payment
  - h. Integrated Finance and Delivery System
- 152.** “**Warm Handoff**” means the process of transferring a Client from one Provider to another in a Culturally Responsive manner, honoring the Member’s choice. A Warm Handoff includes face-to-face meeting(s) with the Client prior to discharge or transition between Providers, and which coordinates the transfer of responsibility for the Client’s ongoing care and continuing treatment and services.
- 153.** “**Waste**” means over-utilization of services, or practices that result in unnecessary costs, such as providing services that are not medically necessary.
- 154.** “**Withhold Month**” means the month in which an APP will be applied to a Capitation Payment.
- 155.** “**Work**” means the required activities, tasks, deliverables, reporting, and invoicing requirements, as described in Section 3-Scope of Work of this RFA and in the Sample Contract.
- 156.** “**Wraparound Care Coordination**” means the act of developing and organizing Child and Family Teams to identify strengths and to assess and meet the needs of Members 0–17 (or Members who continue receiving Wraparound services from 18- 25 years of age) with complex Behavioral Health problems and their families. Wraparound Care Coordination involves:
- a. Coordinating services such as access to Assessments and treatment services;
  - b. Coordinating services across the multitude of systems with which the Member is involved; and
  - c. Coordinating care with Child Welfare, the juvenile justice system and/or developmental disabilities system to meet placement needs.

157. **“Wraparound Review Committee”** reviews and selects entering Wraparound clients according to locally established criteria. Referral information will be collated by the Referral source and communicated to the review committee through the Coordinated Care Organization. The review committee will include young adult/youth and families or Family/Youth Partners on a team of cross-system stakeholders that review Referrals of Wraparound Assessment and screening information, to ensure shared decision making. The review committee will assist in the management of the targeted number of participants, analyzing the types and mix of Referrals, and looking for patterns and disparities in Referrals. Federal level confidentiality standards applicable to all involved systems will be maintained. Transitions out of SOCWI(System of Care Wraparound Initiative) will be reviewed to ensure maximal opportunity for incoming Referrals to be served.
158. **“Wraparound”** means a definable, team-based planning process involving a Member 0-17 years of age (or Members who continue receiving Wraparound services from 18-25 years of age) and the Member’s Family that results in a unique set of Community services, and services and supports individualized for that Member and Family to achieve a set of positive outcomes.
159. **“Year 1”** means 2020. Years 2 through 5 mean 2021 through 2024.
160. **“Youth Partner”** has the same meaning as Youth Support Specialist as defined in OAR 410-180-0305(22).